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FAMILY PRESERVATION JOURNAL

A Publication of the *Family Preservation Institute*

Volume 3 Issue 1 1998

ARTICLES

The Role of Consistency and Diversity in Building Knowledge in Family Preservation

Debora J. Cavazon Dylla and Marianne Berry

The Weekly Adjustment Indicators Checklist: An Application in the Child Welfare Field

*Michael H. Epstein, Madhavi Jayanthi, Janet McKelvey, Deborah Holderness,
Erin Frankenberry, Cassandra Lampkin, Molly McGrath, and Kari White*

Intensive Family Preservation Services: A Short History but a Long Past

Kellie B. Reed and Raymond S. Kirk

Collaborative Conversations for Change: A Solution- Focused Approach to Family Centered Practice

Donald F. Fausel

PLUS a review of current resources



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Provide five copies of the manuscripts. the title page only should list the author's name, affiliation, address, and telephone number. The author's name must not appear after the title page; only the title

should appear on the abstract and first page of the text. Include an abstract of about 100 words.

Please submit all materials to **Family Preservation Journal**, Department of Social Work, New Mexico State University, P.O. Box 30001 Dept. 3SW, Las Cruces, NM 88003-8001.

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Editorial

The Role of Families

Family Preservation is an approach based upon a set of principles and values that are integrated throughout all human systems and services. One of the key principles of Family Preservation is the family as an expert.

Several years ago at a Family Preservation Institute Conference, Sharon Sheldon confronted me, in my role as conference chair, regarding the lack of workshops for and by families at the conference. I tried to explain that this conference was designed for those doing Family Preservation work. Through Sharon's perseverance and the work of Patti Derr, Susan Rogers, and many other incredible family care givers, families slowly are being recognized as experts "doing" the work of family preservation and support.

From "case" conferences to major planning efforts, their insight and unique perspective is extremely powerful. Ray Worsham, charged with implementing the Family Preservation and Support Act in Texas in 1994, convened a panel of eight different family representatives for a day-long discussion with the planning committee consisting of leaders of 40 state and private agencies. In articulate, strong voices, these parents explained how workers, services, and programs sometimes supported them, failed them, and confused them. Their insight gave the planning committee a new focus and fostered one of the most cooperative cross-agency efforts this author has ever witnessed. We have so much to learn from families when we listen.

Family members do not always speak in the jargon of professionals or at the same rate or from the same case outline. If we ask families to participate as professional helpers, then we must invest in preparing families to speak to us. Listening to families is one small but important step toward fully recognizing and using family members' expertise.

What follows is a special message from one family, the Alexander family. Ms. Alexander presented these remarks during the keynote address at the Family Preservation Institute Conference in Corpus Christi, Texas, September of 1997. With her permission, we present her perspective here.

Alvin L. Sallee

Five Things a Case Worker Should Remember When Working with Clients

1. Even though you are a Child Advocate, you need to work with the entire family. Children have fathers and mothers and brothers and sisters that they love very much. In fact, the child(ren) probably loves them more than the child loves you. So, it does no good to mistreat the parent or be rude to the parent, especially in front of the child(ren).

The child(ren) will be angry and resentful of you. You will be working with an angry perpetrator and an angry victim. This cannot be healthy for you, the caseworker for the family.

2. You are a social agency! A government agency of the people! A service agency! Be honest, sincere and helpful. Explain the problems so the parent can understand why it is important to change. Talk about the benefits of changing an act. Don't be rude and confrontive; leave that to the investigator (unless you are the investigator; then you have to. It is expected). The problem with investigators is they sometimes go looking for problems, assuming the worst, instead of being objective and letting the evidence speak for itself. Otherwise, remember the investigation is over, and the case already has been decided as guilty or risky. So, let's get started with the services.

Give feedback on progress or problems so there are no surprises when you evaluate the family later down the line. Give the family a chance to correct any problems. Help them along the way. Don't just say these are your problems then disappear and come back at the end of the month to evaluate them. You can't just leave the family alone all month and then come judge the situation by one visit or what one person, usually the neighbor, says. That is not fair. Say things like "Good job" or "Work on this."

3. Please answer your phone or respond to messages promptly. We are calling with questions or need help. We are not an interruption of your work; we are your work.
4. Ask me what I need all the time. I may be too shy or too proud to ask for detergent. If our clothes are dirty, figure it out. If my dishes are piled up, I may need some dishwashing liquid. If I don't offer you coffee or a soft drink, I may not have any to give you. You also may ask if I have food, especially toward the end of the month.

Tell me what is available in the community for my kids and for me. Tell me about legal aid in case I need it. Tell me where to get free immunizations. Tell me where I can get medical care for free if I can't get Medicaid.

5. We don't always have to meet at your office or my home. Take us somewhere like a park. We never get to go because we don't have transportation, because I don't have family or friends to take us. Help us live like everyone else once in a while. We get tired of being cooped up at home all the time. Help us benefit a little from your intervention.

*Shawna Alexander
Corpus Christi, Texas*

The Role of Consistency and Diversity in Building Knowledge in Family Preservation

Debora J. Cavazos Dylla and Marianne Berry

Family preservation has been criticized for implementing programs that are not theoretically founded. One result of this circumstance is a lack of information regarding processes and outcomes of family preservation services. The knowledge base of family preservation is thus rather limited at present and will remain limited unless theory is consistently integrated within individual programs. A model for conceptualizing how theoretical consistency may be implemented within programs is presented and applied to family preservation. It is also necessary for programs to establish theoretical consistency before theoretical diversity, both within individual and across multiple programs, in order to advance the field in meaningful ways. A developmental cycle of knowledge generation is presented and applied to family preservation.

Family preservation has been criticized for implementing programs that do not have a clear theoretical foundation (e.g., Heneghan, Horwitz, & Leventhal, 1996; Rossi, 1992; Wells, 1994). While early family preservationists developed programs based on theories such as crisis intervention or social learning, recent programs appear to have been implemented without clear linkages to established or developing (i.e., grounded) theory. This reality exists for a number of bona fide reasons. For example, programs have been established fairly rapidly over the last decade, leaving little time for conceptual development. It has simply been more critical to concentrate effort and resources into getting a program operational rather than assuring that it is a theoretically logical program, particularly as funding has been relatively lucrative. Family preservation's philosophical emphasis on individualized service provision has also allowed, perhaps even encouraged, program developers to be less attentive to the theoretical aspects of programs. Many program components have been instituted without even minimal parameters such that programs are practically indefinable (Warsh, Pine, & Maluccio, 1995). Thus, many program components have been put in place that are philosophically sound but theoretically compromised.

While these actions have been essential to the expansion of the field, family preservation is nevertheless in a difficult position at present. First, without reports of sufficient detail regarding program process and specific program components in existing programs, successful programs are not replicable. Moreover, family preservation programs and studies of family preservation programs to date have not produced results that are largely conclusive regarding impact, effectiveness, or outcomes of family preservation services. Programs are mostly incomparable and results are not reliable, comprehensive, or

generalizable. Results that do exist are helpful only to the program evaluated for the most part. To be fair, family preservation is not necessarily any more remiss than other human service fields in assuring the theoretical integrity of its programs. However, because family preservation has been touted as a major costs saver and as "the" solution to today's family problems, its inability to show conclusive findings (much less conclusive positive findings) is a glaring problem for the field as a whole.

Lack of conclusive information has stunted the development of the knowledge base of family preservation. Knowledge regarding "what works" is limited to findings from early studies and from the few experimental and quasi-experimental studies (e.g., Feldman, 1991; Kinney, Haapala, & Booth, 1991; Kinney, Madsen, Fleming, & Haapala, 1977; Pecora, Fraser, & Haapala, 1991; Schwartz, AuClaire, & Harris, 1991) that have been conducted thus far. It is the premise of this paper that family preservation's knowledge base will remain limited unless theory is consistently integrated within individual programs. Knowledge development is a fluid phenomenon that may be achieved through both quantitative and qualitative methods, but theory—developing or established—is the key requirement. Further, it is necessary for programs to establish theoretical consistency individually before theoretical diversity, both within individual and across multiple programs, will be beneficial to the field.

Theoretical Consistency Within Programs

Theoretical consistency within individual programs is essential for the immediate goal of program integrity; in other words, it is necessary for all the parts of a program to logically fit together so that the program itself makes sense. The role of theory in program development is to guide the establishment and continual improvement of the elements of the program. Theoretical consistency within a program can be achieved by assuring that the program components are consistent not only with the overall theoretical foundation of the program, but also that each component is consistent with each other component. A model for conceptualizing how theoretical consistency can be implemented within programs is presented below.

Family preservation programs can be viewed as being composed of three essential elements: goals, a service delivery model, and expected outcomes (see Figure 1). The tie that binds these three elements together is theory. The theoretical perspective adopted by program developers will guide the selection of program goals, determine how services will be provided, and define the outcomes that the program expects to achieve. For example, if the problem a program chooses to address is child abuse, and a theory about child abuse is that improved parental self-esteem decreases the occurrence of child abusive behavior, the goal of the program should be to reduce the occurrence of child abuse; the service delivery model involves the means (e.g., providing counseling three times a week in the client's home) by

which the occurrence of child abuse will be reduced; and the expected outcome is reduced occurrences of child abuse. In this example, all three elements are logically linked to a perspective about human behavior and behavior change, and each element naturally leads to the next element. To reiterate, consistency within programs is achieved when these elements of a program are derived from and are consistent with a theoretical perspective and with each other element. The usefulness of this model for family preservation is explored below.

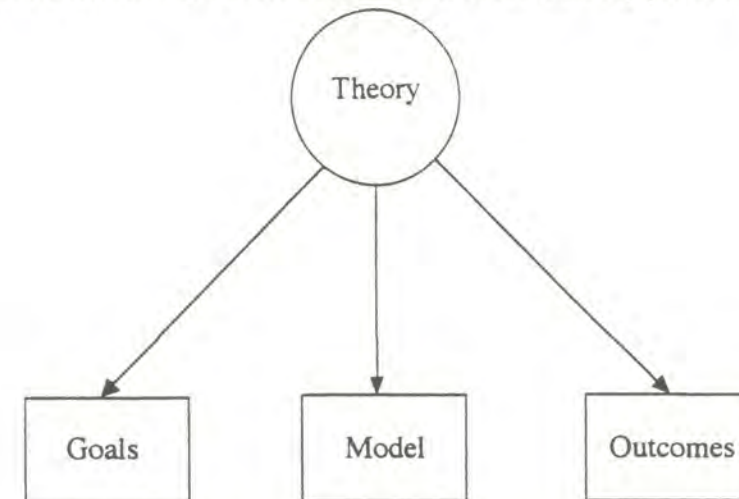


Figure 1. Theoretical Linkages of Program Components

Program Goals

Recent discussions in the family preservation literature have been presented regarding whether family preservation should maintain goals other than the prevention of placement (Bath & Haapala, 1994; Blythe, Salley, & Jayaratne, 1994; Rossi, 1992; Wells & Biegel, 1992). For example, should family preservation maintain the goal of improved family and/or child functioning? As Wells and Biegel (1990) note, "The question is whether it is legitimate for family preservation services to take on more than limited goals" (p. 23). Yet, if family preservation programs are considered capable of maintaining several types of goals *simultaneously*, this debate would not exist. In other words, it may not be so much of a question of which is the right goal, but rather, which is the right goal for the question being asked and for the audience asking?

For example, the issue of whether a program has been implemented in the manner that the program was designed is a *process question* of most interest to administrators; family functioning is a *treatment question* of most interest to workers; and placement prevention is a *policy question* of most interest to administrators, legislators, and funders. All three

types of goals can be established concurrently in family preservation programs, provided the goals are consistent with and derived from the theoretical foundation upon which the program is based (see Figure 2).

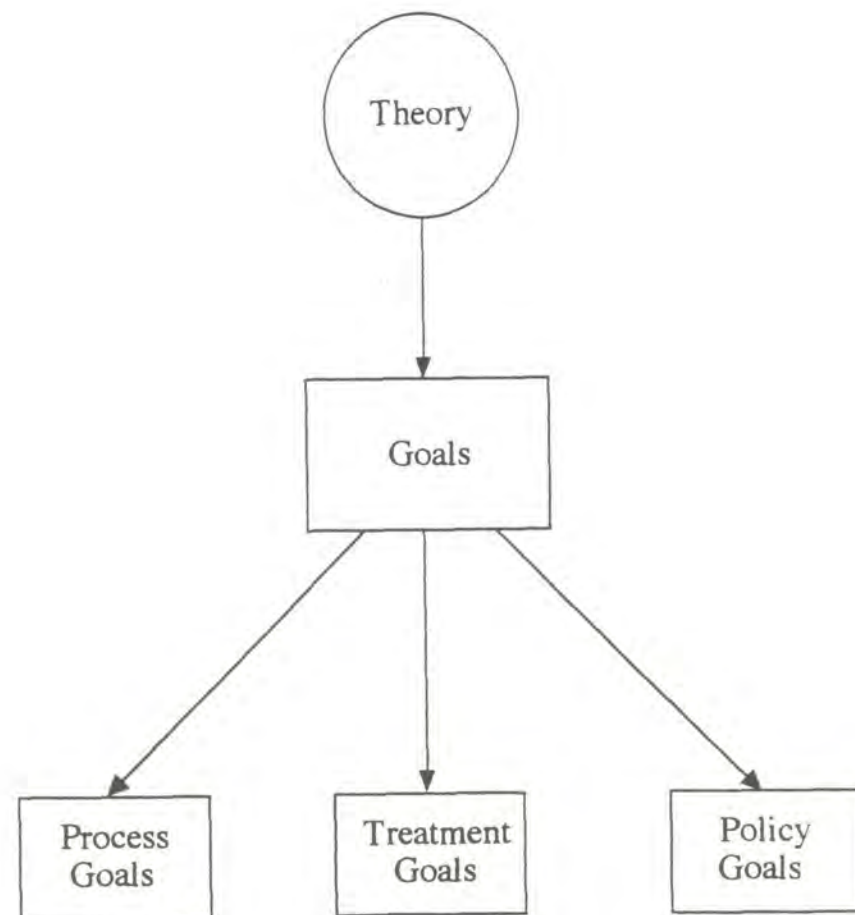


Figure 2. Theoretically Consistent Goals

Process Goals

The family preservation literature has begun to emphasize the need for process information from family preservation programs (Bath & Haapala, 1994; Berry & Cavazos-Dylla, in press; Wells & Biegel, 1992). This need reflects the dearth of information that currently exists regarding program service delivery models in family preservation programs. Process goals that must be examined and established include issues such as whether a program has

been implemented as it was planned, whether service delivery elements are theoretically consistent, whether the program is administered as it was planned, and descriptive information regarding the served population (Rossi & Freeman, 1993). Programs founded on different theoretical bases will not necessarily maintain identical process goals; however, the broad areas of concern should be similar across programs. For example, short-term services provided in the home may be more appropriate for a program based on crisis intervention theory (e.g., as practiced in Homebuilders [Kinney, Haapala, & Booth, 1991]), while long-term services provided in the office may be more consistent with family treatment theory (e.g., as practiced in Oregon's public Intensive Family Services program [Showell, Hartley, & Allen, 1987]).

Process goals are important for establishing internal validity and ultimately external validity (i.e., as replication studies of additional programs continue to reveal internal validity) (Bath & Haapala, 1994), and the assessment of these goals will contribute to and further the knowledge base of family preservation. Multiple studies of process information will likely reveal "what levels of intensity, lengths of intervention, and specific service components produce the best results with [which] populations" (Bath & Haapala, 1994, p. 399).

Treatment Goals

The stated treatment goals of family preservation programs vary, sometimes dramatically. For example, some family preservation experts claim that the goals of programs are to improve or enhance functioning (Bath & Haapala, 1994; Fraser, 1990; D. Nelson, 1990; Tracy, 1991), or to teach families the skills necessary to keep them together (Fraser, 1990; Wells & Biegel, 1990, 1992). Others contend that the treatment goals are to restore the family to adequate functioning (D. Nelson, 1990; Wells & Biegel, 1992), or to resolve, stabilize, or reduce the crisis that led to the need for a referral to services in the first place (Fraser, 1990; Wells & Biegel, 1990, 1992; Tracy, 1991). Still others contend that the goal is to "augment families' tangible resources" (e.g., Fraser, 1990, p. 1). These different goals are reflective of different theoretical bases (e.g., crisis intervention, social learning, ecological) upon which programs are founded; all of these goals are valid, viable, and appropriate and should be measured and reported. It is not necessary for each program to maintain the same treatment goals because all programs do not embrace the same theoretical base. However, learning whether and how these different goals have been achieved is vitally important (in conjunction with process goals information), and necessary for the development of the family preservation knowledge base.

Policy Goals

The one goal where there is unanimous consensus among family preservation programs is the goal of preventing the out-of-home placement of children, even though the articulations

of placement prevention are numerous. For example, the goal is often one of prevention, although the intention of what is to be prevented varies: to avert "the *need* for the removal of children" (D. Nelson, 1990, p. 14); to "prevent [the] *removal* of children from their own homes" (Wells & Biegel, 1990, p. 1); to prevent "the *inappropriate* out-of-home placement" of children (Rossi, 1992, p. 90); or to prevent "the *unnecessary* placement of children in out-of-home care" (Bath & Haapala, 1994, p. 388) [italics ours]. Occasionally, a broad, systemic goal is stated; for example, to "reduce the *proportion* of children in placement who could be served at home" (Wells & Biegel, 1992, p. 25) [italics ours]. Other times, it is a fairly vague goal; for example, "*reaching* children at imminent risk of being removed from their families" (Blythe, Salley, & Jayaratne, 1994, p. 215) [italics ours]. Some experts (e.g., Rossi, 1992; Tracy, 1991) and critics (e.g., Gelles, 1996) contend that family preservation programs should also maintain the policy goal of "the prevention or mitigation of any additional abuse and neglect" (Rossi, 1992, p. 90).

Although the words are different (and this is an issue that must eventually be addressed), the bottom line is that the placement of children out of the home is expected to be prevented in families where the risk of placement is imminent. This is a *policy goal*, a goal that is expected to be accomplished at a somewhat distant time after programs have been in operation for a period of time. It is a goal that can be achieved only if and after the process goals and the treatment goals have been achieved. It is a logical progression of events that if a program is implemented as designed and is consistent with the program's theoretical base, and if the treatment goals have been achieved, then the policy goals should also be achieved. Without the process and treatment goals having been accomplished, the achievement or lack thereof of policy goals is rather meaningless, because it will not be known why or how these goals have or have not been achieved.

All three types of goals are of primary importance to family preservation programs and to the development of the knowledge base. Rather than debating which goals are most important for the field at the current time, it may be more productive to define the types of goals being set, measure their achievement or lack thereof, and report the findings. Family preservation is a field that is too young for prescriptive practices; at this point in time, a lot of information needs to be collected in a lot of different areas from a number of different programs in order to begin to state with conviction what is known and what is of greatest importance.

Service Delivery Models

Service delivery models are composed of all the elements that enable workers to provide services to clients. These elements include, for example, the length of service delivery; how, when, and by whom services are initiated and delivered; the number of cases per worker; worker structure (e.g., single worker or teams of workers); the types of services provided;

the location of service delivery; and hours of operation. Service delivery models also involve staff qualifications, required staff training, and supervision arrangements (Nelson, Landsman, & Deutelbaum, 1990; Weissbourd, 1991). While it is not necessary for every program to implement identical service delivery models (Dore & Alexander, 1996), the service delivery model chosen must be consistent not only with the program's goals, but also the theoretical base of the program. For example, if the theory upon which a child abuse program is based dictates that counseling should be provided as it is requested and that people can be in need of counseling 24 hours a day (i.e., on weekends and in the evenings), it would be theoretically inconsistent for the program to operate only in the morning hours and not at all on weekends.

Nelson, Landsman, and Deutelbaum (1990) note that programs differ considerably in the following service delivery elements: (1) theoretical orientation (e.g., behavioral or systemic); (2) auspice (e.g., public or private); (3) target population; (4) identified problem; (5) primary location of service (e.g., home or office); (6) program intensity (i.e., hours per week of contact); (7) duration of services (i.e., short term to long term); (8) worker caseloads; and (9) teaming arrangements (e.g., single vs. multiple and professional vs. paraprofessional). Programs also tend to differ in client focus (i.e., child or family), availability of services, initiation of services, and types of services provided. Further, because many family preservation programs are new, service delivery models are not usually immediately stable. Often, particularly when a program is new, program elements are adapted in ways that better fit clients' needs or agency policies or other variables (Rossi & Freeman, 1993). This is a necessary part of program development. However, these changes and adaptations must be in accordance with the theoretical base of the program. It is recognized that operating a program serving clients with variable needs and problems often calls for pragmatic changes to program elements. Nevertheless, program developers and administrators cannot be in such a hurry to get programs operating that they change program elements without consideration of the program's theoretical assumptions (Weissbourd, 1991; Nelson, Landsman, & Deutelbaum, 1990). To do so renders the information gained from the program's efforts relatively meaningless.

Wells and Biegel (1990) contend that family preservation programs and research studies of family preservation programs are not grounded in theory:

Families and children are not conceptualized in ways that are tied to theoretical assumptions underlying programs; the theoretical assumptions regarding what works and why are not well tested; and outcomes that are related logically to assumptions underlying intensive family preservation service programs have not been evaluated. The failure to conceptualize research in more theoretical terms makes it difficult to understand the way in which programs work, and ultimately, to enhance the effectiveness of programs and to allocate resources wisely (p. 19).

In essence, Wells and Biegel (1990) and others (e.g., Heneghan, Horwitz, & Leventhal, 1996; Warsh, Pine, & Maluccio, 1995) maintain that the evaluation of programs, particularly of service delivery models, have not been theoretically conceptualized. Yet, a theoretical conceptualization of research and evaluation *studies* of family preservation programs has not or cannot be accomplished without the establishment of a theoretical conceptualization of family preservation *programs* first. In other words, consistency in programs must exist before consistency in evaluation may exist.

There are many clues in the current literature that suggest that family preservation programs are not theoretically consistent in service delivery models implemented. First, many research studies do not report the theoretical orientation of programs. Neglect of this information prevents an understanding of whether the service delivery model in place is even related to the goals, outcomes, or population served. Second, if theory is mentioned, many programs claim to use multiple theoretical bases (Nelson, Landsman, & Deutelbaum, 1990). This practice prevents the ability to show, with any certainty, whether program elements of a particular service delivery model are related to a specific theory. Third, there are wide variations in specific service delivery elements in programs that claim to or appear to use the same theoretical base as other programs (Heneghan, Horwitz, & Leventhal, 1996; Nelson, Landsman, & Deutelbaum, 1990). For example, it is not conceivable for a program claiming to be based on crisis intervention theory to offer services that are anything but immediately initiated if the program is truly based on crisis intervention theory. Fourth, program administrators occasionally appear to pick and choose certain program elements according to convenience rather than because of their appropriateness to a specific theoretical perspective. Although many times these are pragmatic decisions, as mentioned previously, the danger in this kind of practice is that the knowledge base remains undeveloped, and services begin to be provided without any rhyme or reason. Fifth, many programs, if the service delivery model is described, are very nonspecific regarding the elements of service delivery (Bath & Haapala, 1994; Blythe, Salley, & Jayaratne, 1994; Heneghan, Horwitz, & Leventhal, 1996; D. Nelson, 1990; Wells & Biegel, 1990). These problems reveal a clear and overwhelming lack of understanding of the essential role that theory plays in program development, implementation, and operation.

A related area of concern is the lack of consistency between goals and service delivery models. Program developers often overpromise on the goals that a program can achieve. This typically occurs concurrently with the implementation of program elements that are insufficient for achieving those goals. Sometimes agency and policy constraints restrict a program's ability to provide service delivery that is consistent with the program's theoretical base. For example, if a child abuse program's theoretical base contends that abusive parents are embarrassed about behaving abusively to their children, and thus, receiving counseling in their homes will be more dignified than if they have to travel to a specific agency, then program administrators must contend with issues such as worker

safety, worker transportation (to clients' homes), and worker compensation. Because these can be difficult issues and often costly to the agency as a whole, program elements are often compromised. To continue with the above example, if the child abuse program administrators do not compensate workers for traveling to client homes or do not meet the needs of worker safety (e.g., providing car phones, allowing teams to work in the field together), service delivery has been compromised, and the chances of achieving program goals are diminished. Although policy and fiscal concerns are real, the problems that they present must be resolved in ways that will address client and worker needs and also allow a program to maintain theoretical integrity and fidelity. Otherwise, outcomes, the results of a program's efforts, will be irrelevant.

To reiterate, while it is not necessary for all family preservation programs to implement identical service delivery models, it *is* necessary for individual programs to implement theoretically consistent service delivery models. It is not likely that every family preservation program is employing a different theoretical base although the current literature seems to suggest as much; no two programs are alike enough in program service delivery model to be compared. (Whether this is a problem of simply not reporting this information is unknown.) Logically, programs claiming to use the same theoretical foundation should implement the same or very similar service delivery elements. Logically as well, programs using different theoretical bases should institute at least some dramatically different service delivery elements.

These problems of clearly articulated and theoretically consistent service delivery models prevent not only the comprehensive assessment of program processes but also the knowledge of effective program variables, as well as the replication of effective programs (Bath & Haapala, 1994; Blythe, Salley, & Jayaratne, 1994; D. Nelson, 1990; Wells & Biegel, 1990). The lack of a demonstrated link between program service delivery model and theoretical foundation prevents an understanding of whether certain program elements, put in place due to the tenets of a particular theory, actually produce the benefits they are expected to produce. These are issues that must be addressed if the knowledge base of family preservation is to develop.

Theoretical consistency within program service delivery models will lead to the identification of the characteristics of high quality, successful programs, and importantly, will add to and clarify the theoretical knowledge base of "what works" for whom, under what circumstances, and through what program elements" (Weissbourd, 1991, p.81), as well as "how a program functions, whether the program format is effective, and what aspects of the program work best for which families in which cultural [and other] groups" (Unger & Powell, 1991, p. 11).

Expected Outcomes

Finally, outcomes expected from a program must be theoretically consistent with program goals and program service delivery models. Expected outcomes should naturally emerge from the goals of the program (Rossi & Freeman, 1993), and they should not involve more than what the goals outline. For example, if the goal of the child abuse program is to reduce child abuse, the outcome expected is reduced child abuse; a result of reduced child abuse indicates that the goal has been achieved. It would be theoretically inconsistent to expect that the program has reduced poverty, for example. If the program is held to the standard of reducing poverty, it would be deemed a failure, and its success in achieving its theoretically expected outcome (of reduced child abuse) would be woefully ignored.

Because outcomes expected should be consistent with program goals, three types of outcomes can be established and measured (see Figure 3). First, *process outcomes* should be measured by examining whether the service delivery model is faithful to the theoretical base, or whether the program was implemented the way it was designed (Rossi & Freeman, 1993). For example, if the design was for clients to receive services when requested, did clients receive timely services? Second, *treatment outcomes*, or proximal outcomes (Fraser, 1990), examining whether clients benefitted from the program in theoretically expected ways should be measured. For example, if the theory holds that clients who receive services when requested are more motivated to change, was motivation higher for clients who received this program, and did they change more than clients who received the services of a different program?

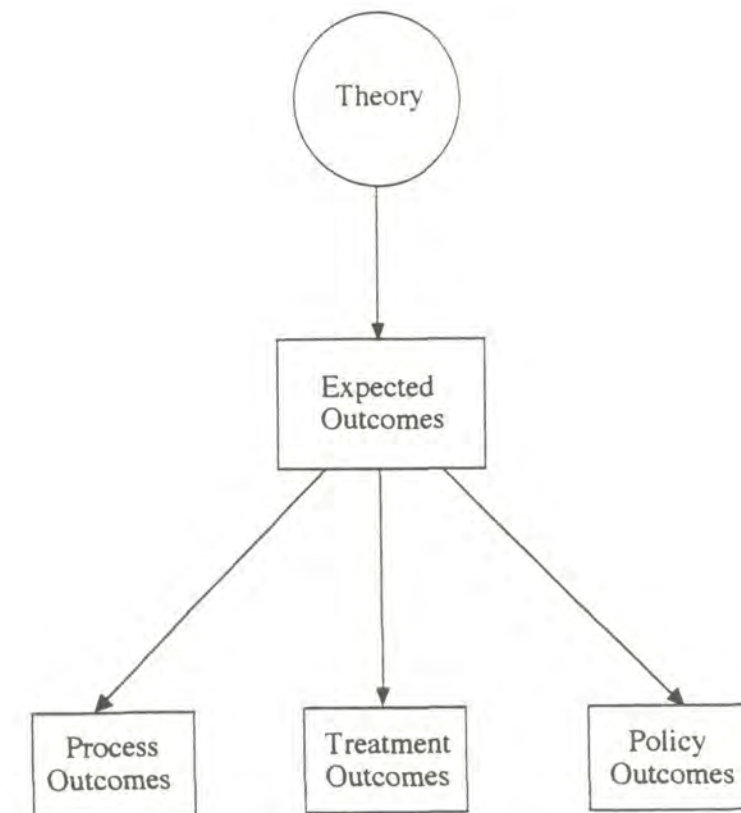


Figure 3. Theoretically Consistent Expected Outcomes

Third, *policy outcomes*, or distal outcomes (Fraser, 1990), those that are more political in nature but dependent on the successful achievement of process and treatment outcomes, should be measured. It is important to recognize that the levels of success of policy outcomes may be small initially, but increase over time. For example, in the child abuse program, a policy outcome may be better academic performance; reducing child abuse in a population may eventually lead to better educational outcomes, but it is likely that this result will emerge over an extended period of time that the program is in existence; it will likely not be an immediate outcome. Importantly, policy outcomes, like process and treatment outcomes, must be theoretically consistent.

There has been much discussion in the family preservation literature regarding the appropriateness of placement prevention for family preservation programs. Some contend that it is a poor measurement of outcome because placement may be a positive outcome for

some families (Bath & Haapala, 1994; Berry & Cavazos-Dylla, in press; Rossi, 1992); because of the indeterminacy and lack of definition of the population of families at risk of imminent placement (Bath & Haapala, 1994; Berry & Cavazos-Dylla, in press; Wells & Biegel, 1990, 1992); because placement figures may actually increase due to greater attention to families in trouble (Bath & Haapala, 1994; Wells & Biegel, 1990); because contextual factors (e.g., placement resources available, differing policies across sites) may be more influential than treatment in determining placement (Bath & Haapala, 1994; Rossi, 1992; Wells & Biegel, 1990); because there is not a universal definition of placement prevention or the experience of placement (Bath & Haapala, 1994; Blythe, Salley, & Jayaratne, 1994; Rossi, 1992; Wells & Biegel, 1990). Most importantly, the use of placement prevention as the only or the most important outcome of family preservation programs disregards the value and significance of process and treatment outcomes.

However, if all three types of outcomes are used and recognized to have equal weight and importance in the long run, the above debate becomes less relevant. The strengths and limitations and developmental appropriateness of each type of outcome should be recognized in order for each type of outcome to serve its purpose effectively. At certain critical periods over the course of a program's development, one type of outcome may be more important than the others, but over the long run, the weight and importance of each outcome should be distributed evenly. For example, when family preservation services began, the policy outcome of placement prevention drove the family preservation movement; it prompted strong support from key decision and policy makers, and an entire generation of family preservation programs were initiated. Today, however, the family preservation movement is in a different stage, and it is becoming more and more pressing to uncover the "black box" (Staff & Fein, 1994) of treatment by examining process and treatment outcomes as well.

Finally, all three types of outcomes are interdependent. Treatment outcomes are reliant on the achievement of process outcomes, and policy outcomes are reliant on the successful accomplishment of process and treatment outcomes. For example, the treatment outcome of higher motivation to change is reliant on the process outcome that services were delivered when clients requested them. The policy outcome of prevented placement is reliant on the successful achievement of the process outcome that services were delivered when clients requested them, and the treatment outcome that motivation to change was higher. The three types of outcomes are so intertwined and dependent on each other that to elevate the importance of one over the others is to disregard the systemic nature of family preservation, its philosophy and its practice.

Consistency within programs produces a program with theoretically consistent program components; all components are linked to the theoretical base; and all components are

linked to each other (see Figure 4). Goals can be accomplished because the appropriate service delivery model is in place, and outcomes can be measured that are consistent with both goals that have been established and the service delivery model that exists. In this way, theory guides the entire process of a program, and all of the parts logically fit together in a cohesive, fluid manner.

The Consistency-Diversity Cycle

The importance of theoretical consistency within programs should not be disregarded as merely an academic exercise. Achieving theoretical consistency may in fact be essential to the survival of the field of family preservation. Establishing theoretical consistency within individual programs will help achieve the more global aim of developing the knowledge base of family preservation. First, it will help family preservation as a practice define itself. There will likely be multiple definitions, which is particularly appropriate for work with clients as varied as families. The importance of achieving definitions, however, is that once defined, programs can be replicated; once replicated, programs can be compared; once compared, knowledge will be generated. Information gained from multiple comparisons about what works as well as what does not work with whom over what time period in what location with what methods and techniques with which workers will be learned, and this information will help family preservation develop its base of knowledge.

One way of realizing the importance of achieving theoretical consistency within programs is to envision it as a stage in a developmental cycle of knowledge generation in a human service field (see Figure 5). This cycle begins with consistency among programs and ends with diversity within programs. Consistency among programs represents the establishment of a philosophical values and beliefs foundation of a field; this stage is completed when multiple programs adopt the same philosophy regarding human behavior and behavior change. Consistency within programs reflects the importance of establishing theoretical integrity in individual programs. Diversity among programs represents the existence of philosophically consistent but theoretically diverse perspectives across programs. Finally, diversity within programs reflects the idea that once knowledge is gained from the previous three stages, individual programs will be developmentally ready to experiment with theoretically different program elements. Importantly, this cycle is developmental in that the next stage is reliant upon the previous stage having been completed. The cycle is repetitive in the sense that once the stage of diversity within is entered, new questions regarding the founding philosophical assumptions, values, and beliefs will arise. Knowledge gained will present new questions and the cycle will begin anew.

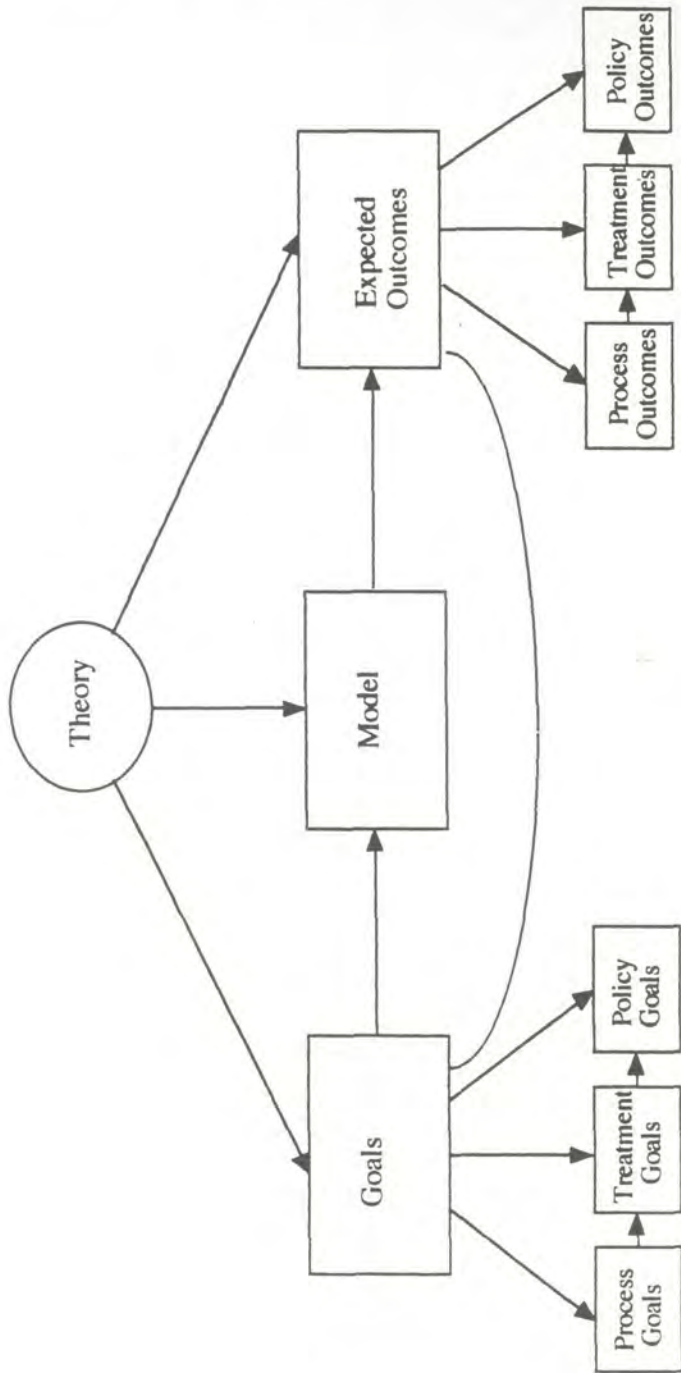


Figure 4. Theoretical Consistency within a Program

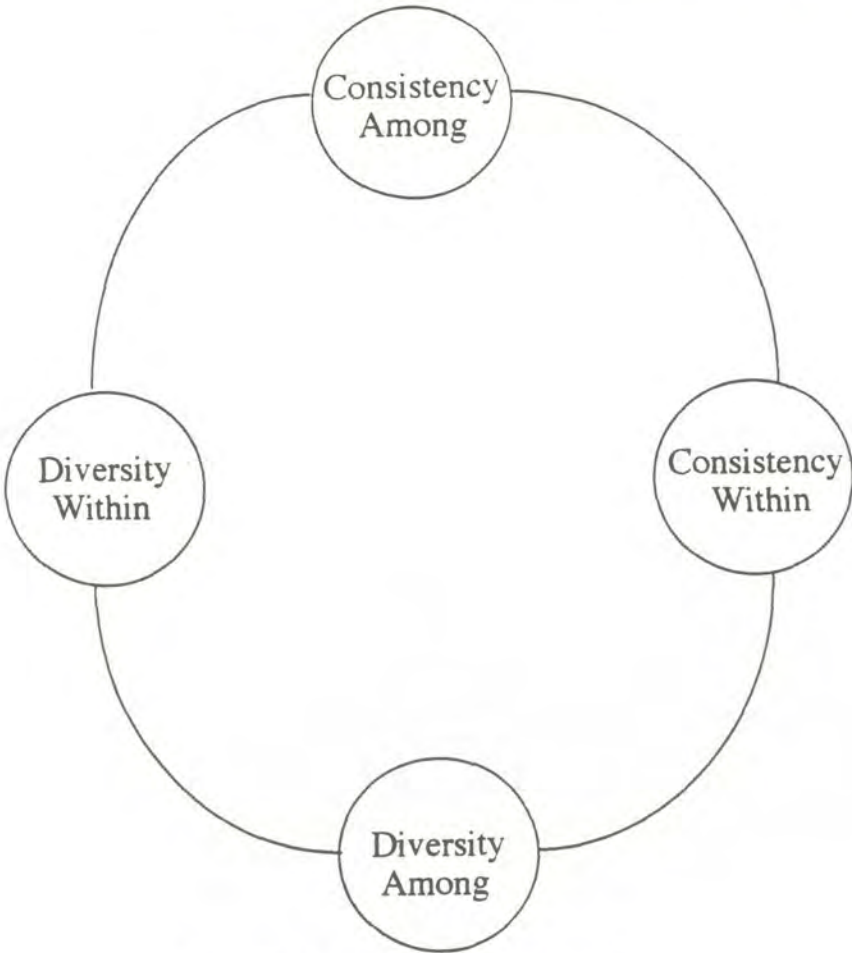


Figure 5. Consistency-Diversity Cycle

The Consistency-Diversity Cycle and Family Preservation

Viewing consistency and diversity as a developmental cycle is only one way of conceptualizing program and knowledge development in family preservation; there are of course alternative conceptualizations. For example, consistency and diversity could be viewed as a continuum, a bi-directional phenomenon where the key characteristics of effective family preservation practice are deduced from diversity. Or consistency and diversity could be disregarded completely as factors in the generation of knowledge. However, it is our view that consistency and diversity are developmental stages; consistency

must precede diversity and there must exist some base (of consistency) from which to diversify. Kinney, Haapala, and Booth (1991), founders of the Homebuilders program, express this developmental perspective and the importance of establishing consistency among programs before establishing diversification:

We urge others considering replication of Homebuilders to try the whole package first and tailor it to their communities *if they encounter difficulties*. [italics ours] If they eliminate one aspect, such as the short time frame or the low caseload, they are likely to decrease the power of the overall intervention far more than they can realize without first attempting the whole model (p. 53). In other words, Kinney and colleagues (1991) assert that the Homebuilders model, if replicated, should be replicated *faithfully*, that is, *consistently* and with integrity, before experimentation with and diversification of the model.

Many theories of human development postulate that the earliest stages of life are the most critical, particularly as they influence the achievement of the later stages of life (e.g., Jensen, 1985; Yussen & Santrock, 1982). In much the same way, successful program development relies on the completion of the stages of consistency, that is, the early stages of the consistency-diversity cycle. Consistency achieved before diversity brings clarity in the definition of programs and the components of effective practice, as well as clarity in defining the foundation of the knowledge base. From this clarity of "what is" (i.e., consistency), experimentation with "what if" (i.e., diversity) will be beneficial to furthering the knowledge base. Defining the consistency-diversity cycle developmentally, and establishing consistency first also brings consensus among the key players in the family preservation field. Consensus among practitioners, researchers, policy makers, and program developers about specific and effective practice components is necessary in order to develop a unifying knowledge base. The stages of the consistency-diversity cycle of knowledge development is applied to family preservation below.

Consistency Among Programs

Consistency among programs, the first stage in the cycle appears to have been completed; family preservation programs seem to embrace the same philosophy about the concept of family preservation. The values of family preservation which guide the practice of family preservation include the following:

- 1) The definition of "family" is varied and each family should be approached as a unique system;
- 2) People of all ages can best develop, with few exceptions, by remaining with their family or relying on them as an important resource;
- 3) Families have the potential to change, and most troubled families want to do so;

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- 4) The dignity and right to privacy of all family members should be respected;
- 5) The family members themselves are crucial partners in the helping process;
- 6) Family members should be empowered to resolve their own problems and avoid dependence upon the social service system;
- 7) The family members' ethnic, cultural, religious background, values, and community ties are important resources to be used in the helping process;
- 8) Policies at the program, community, state, and national levels should be formulated to strengthen, empower, and support families (Lloyd & Sallee, 1994, p. 4).

These guiding values were developed in a national Delphi study of experts in family preservation in the early 1990s (Ronnau & Sallee, 1993) and exemplify that a consistent value base from which programs have developed exists.

Consistency Within Programs

This is the stage where family preservation needs to focus its efforts at the present time. Attending to the theoretical integrity of individual programs will move the field closer to significant knowledge development.

Diversity Among Programs

Diversity among programs can be completed as different programs adopt different theoretical perspectives, as long as chosen theoretical perspectives are consistent with the overall philosophy of family preservation. It is not necessary, nor feasible, for all family preservation programs to use the same theoretical base. It is expected that different programs serve different populations with different problems, strengths, and needs. The expected policy outcome for clients in these different programs may be the same, that is, preserved families. However, the different populations and the different problems, strengths, and needs these populations present may necessitate entirely different theoretical bases. Different theoretical bases will likely result in different goals, different service delivery models, and different expected outcomes. This is completely acceptable, provided that the theoretical bases chosen are consistent with and reflective of the philosophical base of family preservation.

The successful completion of the diversity among programs stage will be based on the successful establishment of the earlier stages of consistency, i.e., faithfulness of multiple programs to one philosophical base and, simultaneously, program integrity within each program. Diversity among programs is a developmental stage that logically follows consistency.

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Diversity Within Programs

Family preservation appears to be in the diversity within programs stage at the present time. Yet, as mentioned, without having the previous stages established, it has proven to be difficult to advance the knowledge base of family preservation. Essentially, each family preservation program is its own model, using not only differing but often multiple theoretical bases, program goals, service delivery models, and expected outcomes. This would be appropriate for this stage except that the knowledge base of family preservation is not developed enough at this time for studies of these diverse individual programs to be fully meaningful.

For example, it has not been established yet which theoretical perspectives are most appropriate for family preservation clients; who family preservation clients are (Heneghan, Horwitz & Leventhal, 1996; Wells & Biegel, 1990); which program elements work best with which family preservation clients; whether clients are achieving treatment outcomes, that is, benefitting from services in theoretically defined ways (Besharov & Baehler, 1992; Heneghan, Horwitz, & Leventhal, 1996; Nugent, Carpenter, & Parks, 1993). It is not known whether clients in a crisis intervention theory based program are more motivated to change than clients in a social learning theory based program. It is not known whether clients benefit more from short-term or long-term services, or whether clients benefit more from a single worker or a team of workers (Wells & Biegel, 1990). If the knowledge base were more developed and some of these unknowns were known, studies of programs that are diverse within would be meaningful from a comparative standpoint. In other words, programs experimenting with program elements (i.e., goals, service delivery models, expected outcomes) could be compared to programs with established effective elements. However, it is only reasonable to mix the variables once it is known what the variables are and what they achieve. Diversity within programs is beneficial only when a knowledge base has been developed. Family preservation is not yet ready to be involved in this stage of the consistency-diversity cycle.

Building the Knowledge Base

While studies and evaluations of family preservation programs have revealed some very important pieces of information thus far, it is consistency in theory that will build the knowledge base. The development of a new knowledge base is, thus, dependent upon theoretical integrity in both philosophy and practice. Consistency in theory will guide program developers and administrators in selecting, modifying, and improving the components of developing and existing programs. In this way, program goals, service delivery models, and expected outcomes will logically and naturally fit with one another

and as a whole. Ongoing evaluations of programs that are clear in their theoretical approach to family preservation, then, will be helpful not only to the individual program being evaluated, but also to development of the knowledge base.

The consistency-diversity cycle presented in this paper is a developmental model for conceptualizing how knowledge can be generated within a field. It has been offered in order to emphasize the grave importance of establishing consistency in family preservation at the present time. It is a model that not only embraces the complexity of family preservation as both a philosophy and a practice, but also addresses simultaneously research, theoretical, and practice issues. Developmentally, the family preservation field is at the stage where consistency within programs is essential. It is crucial not only for the development of the knowledge base but also for the future of family preservation that this stage be completed.

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The Weekly Adjustment Indicators Checklist: An Application in the Child Welfare Field

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Molly McGrath, and Kari White

Research on the effectiveness of various home-based interventions implemented in the 1980s and 1990s indicates that results have been equivocal. Because of the unique and complex behavioral challenges presented by each family and the need for individualized treatments and long-term interventions for these families, group research and evaluation designs are often insufficient in assessing effectiveness of home-based interventions. Alternative evaluation strategies are needed. The purpose of this exploratory study was two-fold: (a) to investigate the applicability and acceptability of the Weekly Adjustment Indicators Checklist (WAIC) in monitoring adult and child behaviors and (b) to monitor, on an on-going basis, the progress of a family referred to an urban family preservation and reunification program. The target family on whom data were collected consisted of a 13-year old girl and her foster parent who was her maternal aunt. The findings of this study indicate that the WAIC is applicable in monitoring the progress of children and adults in care and that it has the endorsement of its user, namely, the direct care provider. Other results of the study, limitations of the study, and future research needs are discussed.

In recent years, the child welfare system has witnessed an exponential growth in the number of children needing care due to factors such as an increase in the incidence of child abuse and neglect cases, breakdown of traditional family structure and extended family support, and rise in the number of low-income families. Consequently, there has been a dramatic increase in the number of children and youth being served in out-of-home foster care placements, and the number of such placements is estimated to reach 550,000 children by the mid-1990s (Children's Defense fund, 1992; National Commission on Children, 1991; U.S. General Accounting Office, 1993). Traditionally, children and youth have been served in one or more of the following out-of-home foster care placements: (a) regular family foster care (i.e., placement with a family that is not biologically related), (b) group care (i.e., small group homes, residential institutions), and (c) kinship care (i.e., placement with relatives). However, these traditional ways of serving children and youth have been intensely scrutinized and ardently criticized by social workers and allied professionals (e.g., Bath,

Richley, & Haapala, 1992; Feldman, 1991; Pecora, Fraser, & Haapala, 1991, Scannapieco, 1994). Several shortcomings of out-of-home substitute care have been identified: (a) children drift from one foster home to another without a sense of permanence; (b) children placed in foster care are rarely reunited with their families; (c) siblings tend to get separated in the foster care system; (d) out-of-home placements do not help prevent repeat cases of abuse and neglect in families; and (e) programs that are curative in nature do not prevent out-of-home placements by teaching families coping skills that will empower them to help themselves and their children.

In response to these shortcomings, there has been a movement in the child welfare field towards alternate ways of serving children and families. These new child care services have emphasized two philosophical viewpoints: family preservation and family reunification. Child care services that stress family preservation are focused intensively on the whole family and are designed to prevent the removal of children from their own homes for placement into out-of-home foster care. The goals of such services are to resolve the crisis that led to the decision to remove the child from the home and to teach the child's family the skills they need to stay together (Wells & Whittington, 1993). On the other hand, child care services that underscore family reunification are designed to help reconstitute separated families. These programs work towards reuniting children placed in out-of-home foster care with their natural biological parents (Fein & Staff, 1993). Both family preservation and family reunification services enjoy considerable public (e.g., The Adoption Assistance and Child Welfare act of 1980) and professional (e.g., Fein & Staff, 1993; Forsythe, 1992) support.

The child welfare system has been criticized not only with respect to the placement issue, but also in two other areas; namely, (a) methodological soundness of research investigations and (b) outcome data on individuals in care. Even though the field of child welfare is replete with research studies, investigations that are methodologically sound are few (Burchard & Schaefer, 1992; Rossi, 1992). Methodological questions have been raised about the dearth of true experimental designs, lack of random assignment of individuals to a treatment group or a comparison group, and lack of appropriate control groups (e.g., Rossi, 1992). Given the ethical and legal factors that argue against the use of sound experimental strategies, alternatives such as quasi experimental designs need to be explored by individuals researching and evaluating child welfare services.

Another area of concern is the paucity of outcome data on children and families in care. Researchers have expressed frustration about the lack of the continuous collection of measurable and observable data on children's and families' goals and objectives in such important life domains as education, social skills, mental health, and parenting skills. For instance, Burchard and Schaefer (1992) note that while service care agencies often gather

information on the number of children being served, their characteristics, type and intensity of placements, and cost of services, very few compile objective data on the progress of children and families on a regular and timely basis. Many important questions regarding the development and improvement of children and families go unanswered. For example, are the children attending school daily? Do the children have good peer/sibling relations routinely? Are the children involved in gang activities regularly? Did the parent/guardian physically abuse children routinely? and Did the parent/guardian provide and maintain shelter daily?

Clearly, there is a need to collect meaningful outcome data on a regular, on-going basis. Data collected routinely and in a timely manner can help direct service providers in monitoring child and family progress effectively and also in developing better treatment plans for individuals in care. Also, systematic, on-going data collection can enable a child care agency to monitor the outcomes of their cases more effectively. One instrument that enables service providers and case managers to track client progress routinely is the *Weekly Adjustment Indicators Checklist* (WAIC) (Burchard & Bruns, 1992). The WAIC provides a measure of behaviors and events that are believed to relate to a child's risk of movement to a more restrictive placement (Burchard & Schaefer, 1992). The WAIC was originally developed to evaluate the mental health status of children and adolescents, and thus consisted of items that were mainly deficit-oriented (e.g., physical aggression, theft, suicide attempt). Even though deficit-oriented items provide useful information regarding the behavior of an individual, the importance of strength-based items (e.g., motivation, self-confidence) cannot be overlooked (Epstein & Sharma, 1997). Progress information on the strengths of an individual can be uplifting and motivating to both the individual being monitored and the direct service provider working with that individual (Dunst, Trivette, & Deal, 1994; Saleebey, 1992). Obviously, the need to modify the WAIC by increasing the number of strength-based items and the need to determine the usability of the modified WAIC in monitoring behaviors related to the child welfare area is evident. Thus, the purpose of this exploratory study was two-fold: (a) to investigate the applicability and acceptability of the modified WAIC in monitoring adult and child behaviors, and (b) to monitor, on an on-going basis, the behavioral progress of a child and adult receiving services in an urban family support program.

Method

Setting

This study was conducted at Kaleidoscope Inc., a not-for-profit child welfare organization in Chicago, Illinois. Kaleidoscope provides unconditional, comprehensively individualized services that are based on the unique circumstances presented by each of the 600 children and families served. Families may be served through one of three basic programs: a

therapeutic foster family environment, an independent living program for older-age adolescents, and a family preservation setting. In January 1994, Kaleidoscope received a grant from the Annie E. Casey Foundation to evaluate its family preservation program referred to as the Satellite Family Outreach Program. This study is one component of that overall program evaluation.

The Satellite environment serves approximately 48 families at any one time and employs a staff of two administrators, three supervisors, four social workers, and 16 family workers. Each Satellite family is served by a five-person team of four family workers and one social worker. Family workers provide a wide range of direct and collateral services; social workers coordinate clinical services. Families are typically referred to Satellite for one of two general reasons: prevention of placement outside the home for at-risk children and youth or reunification with their families for children and youth already placed outside their homes. Given availability of an opening in the program, Satellite has a no-reject admission policy and an unconditional care intervention philosophy.

Participant¹

The target family consisted of a 13-year old girl, Linda, and her foster parent, Janet, who is her maternal aunt. Linda attends grade 6 in the Chicago Public Schools. Janet is a single parent and has three children of her own. Linda and Janet are African-Americans. The primary language spoken at home is English.

In 1985, Linda and her brother were removed from their natural home after their mother was incarcerated for severely abusing her children, and the whereabouts of the father was unknown. At the time of removal from their natural home, Linda was three years old and her brother was five years old. Shortly after, the Illinois Department of Child and Family Services (DCFS) was awarded their guardianship. DCFS then placed the two children with their maternal aunt, Janet, with whom they have lived for the past 11 years. At the time of placement, Janet was married, had 7 of her own children, had 3 children and one grandchild living at home, and was employed as a factory worker. While with their maternal aunt, their Uncle Bob died, Janet became unemployed, and several of Janet's children frequently moved in and out of the house. Except for counseling services offered to Linda and her brother, no other services were provided nor were attempts made to reunify Linda and her brothers with their mother or stepfather. Several problems were encountered in this foster care placement including lack of sufficient adult monitoring of the two children, discipline, and support for attending school and school-related activities. In school, Linda had been identified as having behavior disorders and was placed in special education. Her teachers at school identified chronic truancy, poor attendance, tardiness, oppositional behavior towards people in authority, conduct disorders, and academic underachievement (especially

in English and Math) as some of the problems at school. In 1995, Linda, her brother, and her maternal aunt were referred by DCFS to Satellite.

Treatment plan and services. Linda and her foster parent were referred to the Satellite Program for two reasons: (a) to help improve Linda's academic performance and related school behavior and (b) stabilize the foster family placement. The Satellite family workers provided direct and indirect services to Linda and her maternal aunt. For Linda, the workers monitored her school grades, talked with her teachers, represented her at school staffings, advocated for a new individualized educational plan, helped with homework, and transported her to medical appointments. The non-Satellite services arranged for Linda included individual counseling, planned parenthood, special education, and psychological testing. For Janet, the family workers provided in-home individual counseling focusing on nutrition, housing, child rearing, and supervision practices.

Instrument

The *Weekly Adjustment Indicators Checklist* (WAIC) has two versions: an adult version and a child version (children 6-18 years of age)². Each of the checklists contains 13 items; six strength-oriented items (e.g., encouraged children to go to school), six deficit-oriented items (e.g., physical abuse), and one open-ended item (e.g., other). The child version was developed first, and the adult version was developed later using the same format.

The WAIC was originally developed by John Burchard, University of Vermont, for use as part of the Vermont Community Adjustment Tracking System (VT-CATS) (Burchard & Bruns, 1993). VT-CATS was used to evaluate the outcomes of a community-based effort to serve children with serious emotional disturbance (Burchard & Schaefer, 1992). The psychometric properties of the WAIC have been reported to meet acceptable standards, specifically in terms of the instrument's reliability, validity, and internal consistency (Bruns, Froelich, Burchard, Yoe, & Tighe, 1995). The WAIC used in this study was collaboratively developed by the evaluation team members and the Satellite staff members in the following manner. First, the evaluation team members and three Satellite staff reviewed the original WAIC (Burchard & Schaefer, 1992) that contained 24 items (18 negative and 6 positive behavioral items). Because the scale contained too many items that were deficit-oriented, placed too much emphasis on mental health issues, and did not focus on the behaviors most important to the clients and Satellite staff, it was determined that the scale needed to be revised. Second, the evaluation team kept 10 of the original 23 items and added four additional items that were strength-based and/or relevant to the Satellite program. Third, the 14-item version was piloted by three families and three family workers who completed the scale on one child each for a two-week period. Finally, based on the feedback from the families and staff who piloted the scale, two additional items were deleted and one item was

added. Also, operational definitions for each of the remaining items were reviewed and revised and the response format was finalized. The version of the child WAIC used included 13 items. The adult WAIC was developed in a similar manner.

The response format for each version of the WAIC is identical. For each item, the family worker is to note the presence ("yes") or absence ("no") of the behavior for the week. Then, for each behavior that was present, the family worker is to write in the number of days in which they occurred. The number of days is based on information the family worker secured from home observations, other family workers, and family members. The Adult and Child versions of the WAIC are presented in Figures 1 and 2.

Data Collection

All data were collected by a family worker who was assigned to the case. The family worker was trained in the task of completing the adult and the child WAICs by a member of the evaluation team. The checklists along with the operational definitions of the questions, the behavioral categories (e.g., sadness, gang involvement), and the response format were explained to the family worker by an evaluation team member. The family worker practiced completing the checklists for a two-week period. During this period, the evaluation team member provided feedback to the family worker on the accuracy of the completed checklist. Following this two-week training period, the family worker started collecting data on the case and was supervised by the evaluation team member on a weekly basis.

Data Entry and Reliability

A software package was developed by Froelich (1993) for the purposes of (a) tabulating the data collected from the adult and child WAICs and (b) graphically reproducing the tabulated data. All data from the child and adult WAICs were entered into these computerized databases by one member of the evaluation team. In order to determine the accuracy of data entry, another member of the evaluation team re-entered part of the adult and child WAIC data into the databases. Reliability was performed on 20% of all data entered under each behavioral category (e.g., sadness, gang involvement). Reliability was calculated using the following percentage agreement formula: number of agreements divided by the number of agreements plus number of disagreements and multiplied by 100. Reliability was 100% for each of the behavioral categories.

Child _____ Completed by _____

Week Beginning _____ Number of Satellite contacts this week _____

Directions: Please indicate according to your best judgment whether or not the following behaviors or events occurred in the past week. If a behavior or event did occur, please indicate on how many days the behavior occurred. Respond on the corresponding line: 0-7 days.

	Yes/No	# of Days
1. ADULT CONTACT: Did the child or youth have contact with an adult (other than the parent, excluding Kaleidoscope workers) who provided care/supervision for the child or youth?		
2. ALCOHOL/DRUG USE: Did the child or youth use illegal drugs or alcohol this week?		
3. GANG INVOLVEMENT: Was the child or youth involved in gang activities this week?		
4. MOTIVATION: Did the child or youth show real effort, interest or motivation in a hobby, activity, or goal this week? If yes, name the hobby, activity, or goal. _____		
5. PARENT SUPPORT: Did the child or youth have quality interactions with his/her natural or foster parents this week?		
6. PEER INTERACTIONS: Did the child or youth have <u>good</u> peer/sibling relations most of the time this week?		
7. PHYSICAL AGGRESSION: Did the child or youth hit, strike, bite, or scratch a person with intent to harm them this week?		
8. POLICE CONTACT: Did the child or youth have contact with the police or courts concerning his/her behavior this week?		
9. SADNESS: Was the child or youth sad, withdrawn, or depressed to a degree which significantly interfered with his/her participation in important activities this week?		
10. SCHOOL ATTENDANCE: Did the child receive credit for school attendance for all possible days this week?		
11. SELF CONFIDENCE: Did the child or youth appear self confident in his/her activities most of the time this week?		
12. SUICIDE: Did the child or youth have thoughts of committing suicide this week? Or attempt suicide?		
13. OTHER		

Figure 1. Child Weekly Adjustment Indicators Checklist

Adult _____ Completed by _____

Week Beginning _____ Number of Satellite contacts this week _____

Directions: Please indicate according to your best judgment whether or not the following behaviors or events occurred in the past week. If a behavior or event did occur, please indicate on how many days the behavior occurred. Respond on the corresponding line: 0-7 days.

BEHAVIOR	YES/NO	# OF DAYS
1. MONITORING: Did the client provide appropriate care plans for children? Did the client provide a safe home environment (free of physical hazards, broken glass, toxic chemicals, lit stove burners)? Did the client provide adequate supervision for her/his children?		
2. EMOTIONAL STATE: Did the client appear sad, withdrawn, depressed, anxious, fearful, or worried to a degree which significantly interfered with participation in an important activity?		
3. PHYSICAL ABUSE: Did the client spank/hit the child or youth with an object (i.e., cords, shoes) or intensively hit the child with her/his hand?		
4. PHYSICAL AGGRESSION: Did the client engage in physical aggression with peers or adults (i.e., fighting)? Did arguments escalate into physical fighting?		
5. VERBAL ABUSE: Did the client verbally abuse/berate (i.e., holler, scream) at her/his child? Did the client talk "at" rather than talking "with" the child?		
6. SUBSTANCE ABUSE/ALCOHOL ABUSE: Did the client use excessive amounts of drugs or alcohol?		
7. VISITATIONS: If her/his children are in placement, did the client attend visits with them?		
8. PERSONAL HYGIENE: Did the client appear appropriately bathed, dressed, groomed?		
9. PROVIDED AND MAINTAINED SHELTER FOR INTACT FAMILY OR SELF: Did the client provide housing (shelters if family is homeless) for her/his family? Did she/he pay necessary bills, keep appliances working, keep house free of hazards, and maintain a sanitary home?		
10. ENCOURAGED CHILDREN TO GO TO SCHOOL: Did the client encourage her/his children to go to school? Did the client help the child with getting dressed, waking up on time, etc.?		
11. DISCIPLINE: Did the client provide a structured home environment where the expectations for behavior and consequences for behavior are known?		
12. MET FAMILY'S NUTRITIONAL NEEDS: Did the client provide balanced meals (food other than junk food) and keep an adequate amount of food in the house?		
13. OTHER		

Figure 2. Adult Weekly Adjustment Indicators Checklist

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Consumer Satisfaction Interview

In order to determine the degree of satisfaction with the WAIC, the family worker who completed the adult and child versions of the checklist on Linda and Janet was interviewed by one member of the evaluation team. An interview guide covering four topical areas (i.e., time required for completing the checklist, ease/difficulty of the checklist, usefulness of the checklist, and suggestions for improving the checklist), specifying the 10 interview questions and the interview protocol (what should be done/said, how it should be done/said, when it should be done/said) was developed. The evaluation team member who conducted the interview was trained by a senior evaluation team member with respect to the interview protocol. The structured interview lasted approximately 20 minutes and was tape-recorded.

Interview data were analyzed by two evaluation team members who listened to the tape independently and developed case notes for each of the 10 questions. Then, the two evaluation team members met to compare and discuss their notes. Finally, after all disagreements were resolved, a document delineating the findings for each of the four topical areas was developed by one of the evaluation team members.

Results

Data on the child and the adult WAICs were collected by the family worker for a period of 50 weeks or 12 months. The participant, Linda did not use drugs, get involved with gangs, or attempt suicide during the 12-month period. Behaviors such as motivation and self-confidence improved, however, not on a consistent basis. Steady improvement was noted in school attendance, parent support, peer interactions, and adult contacts. The foster mother, Janet, showed consistent improvement in areas such as monitoring, personal hygiene, providing shelter, encouraging children to go to school, discipline, and meeting family nutritional needs. Over the 12-month period, the foster mother was emotionally stable, did not physically abuse Linda, or engage in alcohol/substance abuse. Also during this time period, her verbal abuse directed towards Linda declined.

Data from the child WAIC (Figure 3) and the adult WAIC (Figure 4) are presented as bar graphs. In each figure, data on three behavioral indicators over the 50 week period are displayed. Along the horizontal axis are the 50 weeks and along the vertical axis are represented the number of days each week in which the behavior occurred at least once. For example, in Figure 3 the child behaviors of parent support, peer interactions, and police contact are shown. The weekly data indicates that over the time period Linda demonstrated improvement in peer interactions and received significantly more support from her foster mother. In Figure 4, the adult behaviors of verbal abuse, personal hygiene, and shelter for family or self are presented. The data indicate that Janet reduced instances of verbal abuse and substantially improved personal hygiene and shelter.

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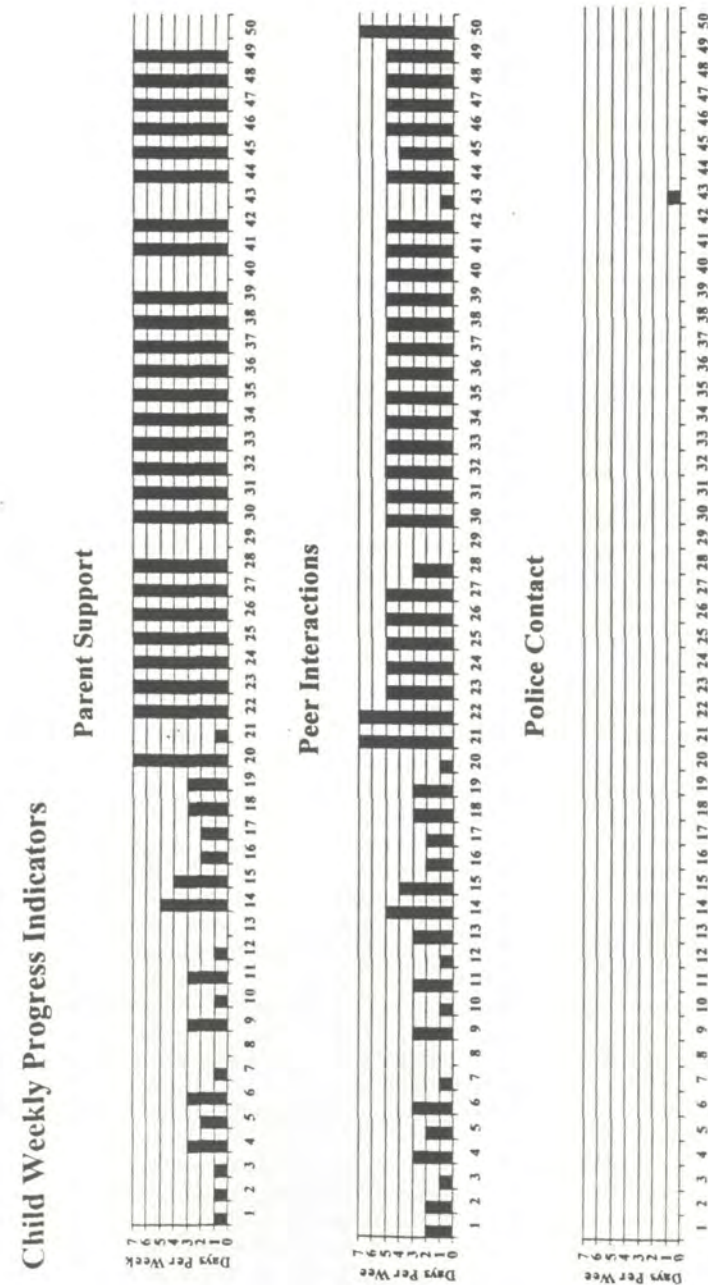


Figure 3. Child Weekly Progress Indicators

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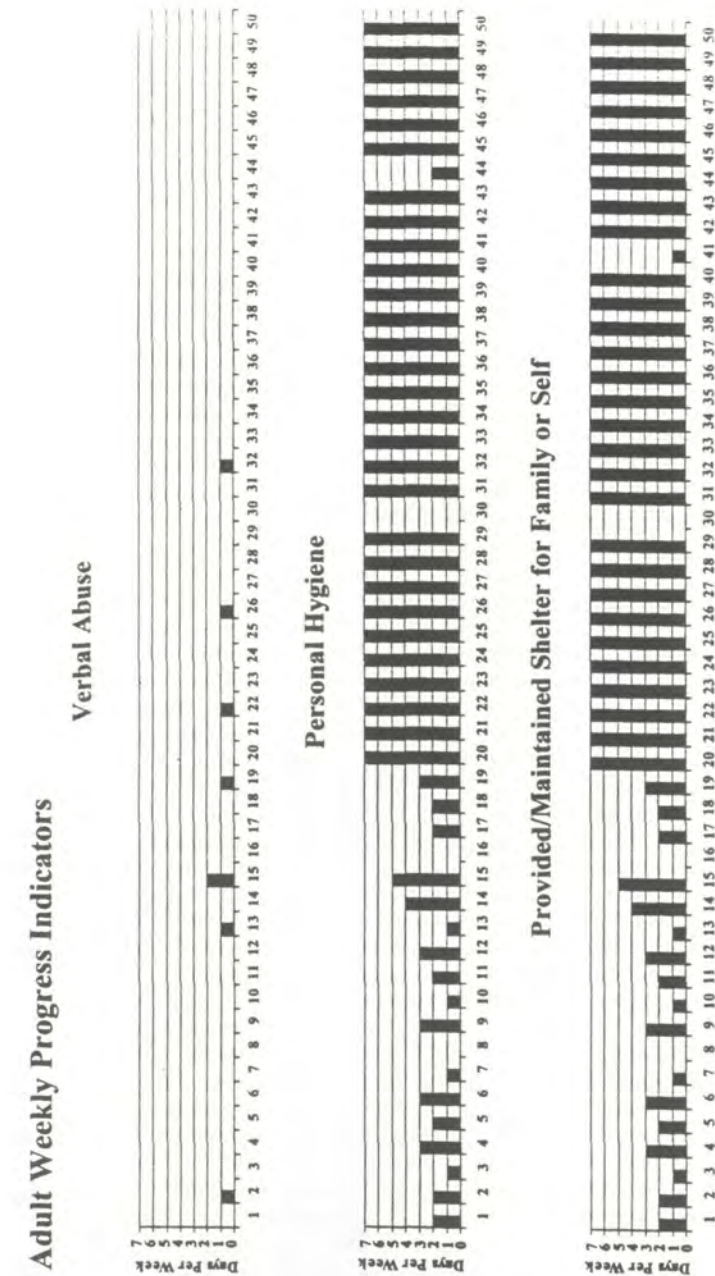


Figure 4. Adult Weekly Progress Indicators

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Consumer Satisfaction Interview

The family worker indicated that it took her 10-15 minutes per week to complete the checklist. On the topic of ease/difficulty of the checklist, she felt that trying to estimate the number of days per week that the behavior had occurred was a difficult task. For instance, she indicated that it was problematic to determine if the child was sad on the days she did not visit the family. Also, the family worker noted that some of the wording on the checklist was unclear and confusing and that consequently this made the task of completing the survey difficult. With respect to the usefulness of the survey, the family worker indicated that the WAIC was a useful tool and that she would not mind having it as a permanent part of the record-keeping procedures at Satellite. The family worker also indicated that the graphical representations of the data were useful in monitoring client status and in developing and reviewing treatment plans. She specifically noted that the positive behavioral changes on the graphs helped motivate her and other staff at Satellite. Finally, the family worker made several suggestions for improving the checklist (e.g., simplify the language, complete the checklist daily).

Discussion

One purpose of this exploratory study was to monitor on an on-going basis the progress of a family receiving services from an urban family support program. The findings of this study indicate that the target family being monitored showed progress with respect to some strength-oriented behaviors over a 1-year period. For instance, the adult (i.e., foster parent) showed optimum improvement in the areas of monitoring child behavior, personal hygiene, providing and maintaining shelter for family or self, encouraging children to go to school, discipline, and meeting family nutritional needs. Similarly, the child (i.e., Linda) displayed moderate improvement in the areas of adult contact, motivation, peer interactions, school attendance, and self-confidence. It is also evident from the data that over a 1-year period, both the adult and the child did not engage in any deficit-oriented behaviors such as suicide attempts, physical abuse, physical aggression, verbal abuse, and substance/alcohol abuse. The findings of this study also indicate that while some of the target family's goals were achieved, some others still needed to be addressed. For instance, the foster family placement was stabilized; however, Linda's school-related behaviors had not reached an optimum level of functioning.

A second purpose of this study was to investigate the applicability and acceptability of the WAIC in monitoring adult and child behaviors on an on-going basis at a family support program. The findings of this study indicate that the WAIC is applicable in monitoring the progress of children and adults in care. For instance, it is clearly evident from the year-long data collection phase that the WAIC can be used by direct service providers on a regular

basis to collect data on individuals in care. Furthermore, data from the consumer satisfaction interview indicate that the WAIC is acceptable and that it has the endorsement of its user, namely, the direct service provider.

The WAIC is a useful data gathering tool at both the individualized case level and at the agency, system level. At the individual case level, direct service providers can use the WAIC in several ways during their day-to-day interactions with their clients. First, they can use the WAIC to monitor the status of specific target behaviors of children and adults in their care. These target behaviors can be not only deficit-oriented behaviors such as theft, physical aggression, and property damage, but also strength-oriented behaviors such as peer interactions, school attendance, and self-confidence. Second, the direct care providers can then use this information on the target behaviors to design and implement more effective treatment plans for their clients. Third, the data can be visually presented in graphs to provide feedback to children, parents, and direct service providers, and can be used to modify treatment plans. In the present evaluation, child and adult graphs, such as in Figures 3 and 4, were presented to the Satellite team every three months as they formally reviewed and adjusted the family's treatment plans. Finally, along with a visual analysis of graphed data, a statistical test (i.e., Kendall's Tau) for trend can be calculated to assess if progress is being made on the target behaviors (Bruns et al., 1995). At the agency level, administrators can use WAIC data in several ways to evaluate the outcomes of services and treatments. First, if an agency focuses on a specific challenging behavior (e.g., police contacts, drug use) shared by many of their clients, WAIC data can be collected across their clients to monitor the outcomes of the treatment regimen. Second, agency administrators can use WAIC data to evaluate the effectiveness of one of their programs or services. For example, the WAIC tracking data on children and adults served in the present study is part of a larger evaluation of the overall effectiveness of the Satellite program. Third, the data can be aggregated across clients, and similar to individual cases, a statistical test for trend can be calculated to assess the direction of change for a group of individuals receiving services.

The family worker who completed the checklist, while discussing the potential benefits and usefulness of the WAIC, also noted ways in which the WAIC could be modified to make it a more effective and efficient tool. For instance, the family worker noted that it took her 10-15 minutes on an average every week to complete the WAIC. In addition, the family worker noted that trying to estimate the number of days per week that the behavior had occurred was a time-consuming and a difficult task. These features of the WAIC may make it less usable in the long run among direct care providers given the reality of their workloads and time constraints.

The need to modify the WAIC further and make it more useful and acceptable is evident from these findings. The WAIC could be modified in three ways to make it a more user-friendly tool. First, instead of having a Weekly Adjustment Indicators Checklist wherein the direct care provider estimates the number of days the behavior had occurred during a week, a Daily Adjustment Indicators Checklist (DAIC) could be used. This checklist could be filled out by one or more direct care providers every time they visit the family, once a week, once a month, once a quarter, or in such a similar manner. The response task on this checklist would entail determining if the behavior had occurred on that particular day and would not require the direct care provider to engage in the task of estimating the number of days the behavior had occurred during a certain time period such as a week. The response task of determining if the behavior had occurred or not on a particular day would not be a time-consuming and difficult activity and would therefore make the DAIC more acceptable among direct care providers. Second, the WAIC could also be made more efficient by individualizing it to the child or the adult being monitored. For example, if behaviors such as gang involvement and suicide are not problem behaviors that have to be monitored for a particular client, then they could be deleted from the checklist and this would help in shortening the checklist. In a similar manner, other deficit and strength behaviors that are applicable to the individual being observed could be added to the checklist, thus making it more individualized to the client. Because the present case study was part of a larger evaluation program, behaviors were selected by staff based on those typically engaged in by clients. Third, in order to reduce the time required for data collection, less frequent measurement of behavior may be warranted. As part of the Vermont evaluation system, Burchard and colleagues developed checklists that assess behavior on a monthly and quarterly basis (Bruns et al., 1995).

Certain limitations of the study should also be noted. First, the generalizability of the findings are somewhat limited given the small sample size. Second, the WAIC was not individualized and therefore was not totally reflective of the child being monitored. Third, the WAIC required the family worker to determine if the behavior had occurred during the week and the number of days during that week that the behavior had occurred. Both these response tasks required a certain degree of estimation and personal judgement as the family worker completing the WAIC did not visit the family on a daily basis and had to depend on other family workers' and the clients' observations to determine if the behavior had occurred or the number of days during which it had occurred. Unfortunately, no data were systematically collected on how reliable the family worker was in estimating the occurrence of the behavior. Despite these limitations, the findings from this study add to the knowledge base regarding the applicability, acceptability, and usability of the WAIC.

It would be unfortunate if the discussion of the modifications to the WAIC and the limitations of the present study distracted from the potential value of the WAIC. The WAIC

was designed for use in the evaluation of a child welfare agency; specifically for the purpose of monitoring on a regular and on-going basis selected behaviors of the child and adult clients receiving services. To this end, the WAIC has achieved its purpose. The WAIC has been found to be helpful in monitoring client behaviors over a significant period of time, to focus on behaviors that are meaningful to child welfare personnel, and to be perceived as user friendly by direct service providers. These points underscore the potential worth of the WAIC to individuals interested in monitoring, researching, and evaluating the outcomes of family support programs.

The results of this study indicate the need for further research in this area. First, a series of exploratory investigations are needed to make the WAIC more applicable and usable. Focus groups and interviews of direct care providers may help in determining the (a) most user-friendly design for the checklist, (b) target behaviors that should be included on the checklist, (c) operational definitions for the target behaviors that will render them observable and measurable, (d) response tasks that are easy and time efficient, and (e) various ways in which the checklist could be individualized. Second, further studies are needed to ensure that data are collected in a reliable manner. This may involve investigating how to train direct service providers to be accurate judges of behavior. Finally, additional studies using the tracking system are need to monitor the progress of individuals in care, and to collect the much needed outcome data on the services provided by child welfare agencies.

The need for on-going outcome data in the field of child welfare must be emphasized. The field of child welfare has a history of research investigations and program evaluations that has given rise to the existence of large databases focusing on issues, such as who is being served and the types of services they receive, while virtually overlooking issues relating to the outcomes associated with those services. Given the current demand by the public and policymakers to document the effectiveness of child welfare services, in general, and family support programs, in particular, public and private child care agencies need to be more cognizant of accountability. Child welfare staff, administrators, and evaluators need to develop accountability systems that not only assess and document outcomes, but also monitor progress of clients on a regular, on-going basis. The client monitoring system used in this study represents one attempt to provide outcome data to address the critical question, "How well are child and families served by family support programs?"

Author Notes

- ¹ Participant information has been altered to some extent for confidentiality purposes and also to protect the identity of the participant.
- ² The original WAIC was modified for use in this evaluation with permission of the developers of the WAIC. A young-child version of the WAIC for children from 0-5 years of age was also developed. Please contact the senior author for a copy of this checklist.
- ³ The X-axis on all the graphs denotes the 12-month period of the data collection phase, while the Y-axis on all the graphs represents the number of days per week the target behavior had occurred.

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Intensive Family Preservation Services: A Short History but a Long Past

Kellie B. Reed and Raymond S. Kirk

Intensive family preservation services (IFPS) is a program model that has been disseminated widely throughout the country, and has received federal recognition and monetary support since the early 1980s. Recently, IFPS has been criticized for seemingly being unable to prevent out-of-home placements. The authors contend that many evaluators and policy analysts have lost sight of the historical roots of IFPS, and are focusing only on recent fiscal and policy contexts when assessing IFPS program effectiveness. This article reviews the therapeutic and programmatic origins of IFPS including desired treatment outcomes, and suggests that evaluators and policy analysts redirect their focus accordingly.

Since the mid-1980s, large increases in the number of child abuse and neglect reports, rising foster care caseloads, and the increasing costs of out-of-home care (Government Accounting Office, 1995) have led to increased attention on programs and policies within the child welfare system designed to prevent out-of-home placement. Among the most well known and controversial of these programs is "intensive family preservation services" (IFPS). Policymakers, child welfare staff, child advocacy groups, evaluators, the media, and others debate whether or not IFPS is effective. "Effectiveness" most frequently is conceptualized as fewer out-of-home placements of maltreated children than traditional services (Feldman, 1991; Fraser, Pecora, & Haapala, 1991; Schuerman, Rzepnicki, Littell, & Chak, 1993; Szykula & Fleischman, 1985; Yuan, McDonald, Wheeler, Struckman-Johnson, & Rivest, 1990).

A focus on placement prevention is supported by the belief that IFPS is a recent innovation resulting from federal legislation. "The Child Welfare and Adoption Assistance Act of 1980," (Public Law 96-272) established broad guidelines in serving maltreated children and their families. The legislation set forth several mandates. First, "reasonable efforts" had to be made by child welfare agencies to prevent the removal of children from their families. Second, when it was necessary to remove children, the law required placement in the "least restrictive setting." Finally, attempting to reunify children with their families, or finding permanent, alternative families were necessary steps in establishing "permanency plans" for the children. These mandates often have been translated into "placement prevention"

initiatives designed to prevent the unnecessary removal of maltreated children from their families.

Although reducing placements is a legitimate goal to be pursued and evaluated, this focus under-emphasizes the importance of other measures, such as changes in child well-being and family functioning (Berry, 1992; Wells & Freer, 1994; Wells & Tracy, 1996). Furthermore, IFPS historically has emphasized both placement prevention and other goals. The IFPS program model can be traced to programs developed in the mid-1950s, and IFPS practice methods and philosophies date back to the early 1900s. The IFPS methods and program model represent advances in working with families and children that have evolved over time, and were derived from methods and models originally designed to enhance child and family functioning, not prevent placement.

The purpose of this article is to redirect attention to the origins of IFPS, and to examine IFPS from that perspective. To accomplish this, the history of family-centered services will be discussed. Second, advances in the development of family-based practice methods and research on those methods will be highlighted. Third, the relationship of IFPS to these advances will be acknowledged. Finally, the importance of focusing on child and family indicators, for which IFPS originally was designed, will be addressed.

History of Family-Centered Services

"Family preservation" is a fairly new term dating back to the 1970s. The term refers to a range of services which are provided to families in their homes, and are designed to preserve and support at-risk families. Although the term is new, the concepts and service principles of family preservation can be traced to the actions of early relief workers in the late 19th and early 20th centuries.

Charity Organization Societies

In the late 1800s, Charity Organization Societies (COS) arose throughout the United States to support poor and dependent children and families through the provision of concrete services (e.g., food, clothing) and financial relief (Henderson, 1904). By providing relief, families were able to meet their basic needs and focus on other concerns (Marcus, 1929). In turn, COS workers "gained" access to families, and identified areas that might be causing underlying problems of poverty and dependence. These problems included difficulties in family relationships, physical health issues, personality and behavior problems, and unemployment (p. 97). Investigation and treatment of the family as a unit were emphasized in some accounts of COS workers (Watson, 1922).

Studies of the effectiveness of COS focused on research questions remarkably similar to questions that permeate the literature of IFPS today. Marcus (1929) conducted a case study of the COS of New York. Like IFPS evaluations, the research questions focused on the effectiveness of the COS, both in terms of methods and costs. They included

- Is the use of relief as a tool of casework economical, well-directed, and effective?
- Are the casework practices used providing the best return for the money spent?
- Is the distribution of funds and services maximizing the time, money, and skill spent on individual cases?
- What other factors promote or prevent the goal of restoring families to economic independence (p. 12)?

The evaluation of this project was a case study. Because of the limitations of a case study design, only descriptive findings and generalizations were reported. First, Marcus (1929) suggested that some families receiving relief might not understand the concept of casework. This lack of understanding might inhibit the effectiveness of caseworkers. Second, he did not find any indications that relief was being distributed for purposes that could be considered "... frivolous, unnecessary, or unrelated to the fundamental casework plans of rehabilitation" (p. 20). Finally, he suggested that relief services could better be directed and distributed through enhanced assessment and understanding of family relationships (pp. 98-101). This last finding foreshadowed family-based projects and treatments that would later be developed.

Another programmatic effort aimed at families was settlement houses. Begun in the early 1900s, they were designed primarily to support immigrant and poor families in local communities (Richmond, 1922). Like the COS workers, settlement house staff assisted families with domestic difficulties, personality problems, child care, health problems, truancy, legal problems, and citizenship (Kennedy & Farra, 1935). Services were mainly provided in the settlement house, but some services were provided in the homes of families.

Movement Away from Families

Even though the COS and settlement houses emphasized family-based service, an underlying belief was frequently espoused by workers—that problems of poverty and dependence are individually based. At the same time, individual dysfunction was becoming the focus of psychiatry and mental health, most notably symbolized by Freud's development of the psychoanalytic model of conscious and unconscious drives (Freud, 1935). Freud believed that unresolved conflicts between competing forces in the unconscious resulted in mental disorder and difficulties for a person. Freud developed the thesis of his work in

Europe. He was the first to discuss psychoanalysis in the United States and was the leader of the psychoanalytic movement in the U.S. (Brill, 1938). As a result, even among social workers in the burgeoning field of social work, a focus on deficits within individuals replaced the previous focus on charitable work with families. This new focus continued for a number of years, "fueled" in part by a need to legitimize the profession of social work.

Re-emergence of Family-Centered Services

A half century after the development of Charity Organization Societies and the settlement houses, which focused on at-risk families and children, other family-based programs were implemented. These programs did not diminish the psychoanalytic movement. Rather, they were implemented concomitantly. Some of these programs strongly resembled intensive family preservation programs of the 1990s. Among the first of these projects was the St. Paul Family Centered Project, developed in the 1950s.

St. Paul Project

A hallmark of this project was a focus on strengths rather than deficits, which also is a major underpinning of modern IFPS. The focus on strengths is evident in the Family Unit Report Study published in 1948 by Buell (1952). This study identified a number of families with multiple needs. The researchers found that 6,600 (6%) of the families in St. Paul used over one half of the community's resources from human service agencies (p. 9). Taking a nontraditional approach to respond to this group of families, the St. Paul project was created with an explicit emphasis on strengths. Prior efforts had emphasized the deficits of family members. Supporting this new approach, the director of the St. Paul project stated, "Probably in an effort to defend themselves against their own feelings of inadequacy at being unable to help such families, caseworkers have tended to put the responsibility for failure upon the family and to say they are not motivated to treatment" (Geismar & Ayres, 1959, p. 5). In contrast, St. Paul Project workers were directed to work with families on a long-term basis, to focus on their strengths, and to meet their specific needs, even if their first attempts did not succeed.

In addition, the project was viewed as a community organization effort rather than casework treatment. Project staff visited at-risk families to offer services, provide home visits, conduct diagnostic assessments, and coordinate other services (Geismar & Ayres, 1959). The staff and other resources voluntarily were contributed by agencies within St. Paul. Target families had children under 18 who were at-risk of delinquency, neglect, or severe health or economic problems (Overton & Tinker, 1957).

In addition to providing services, the project was noteworthy for research (Greater St. Paul Community Chest and Councils, 1958). Between 1956 to 1959, a study of 150 families was conducted. Families who received treatment for nine or more months, and whose cases were closed by the end of 1958 comprised the study sample (Geismar & Ayres, 1959). The researchers developed the Family Profile to measure change in family functioning from intake to case closure. Change was measured in the following areas: child care and training, individual behavior and adjustment, family relationships and unity, social activities, relationship with the worker, use of community resources, economic practices, health problems and practices, and home and household practices. Combining these categories, the researchers found that 65.3% of the families demonstrated positive change, 18.7% did not change, and 16% deteriorated (p. 5).

Much like IFPS today, the researchers attempted to analyze costs. They focused upon public assistance costs associated with General Assistance and Aid to Dependent Children (Geismar & Ayres, 1959). They reported increased expenditures in both programs for Project families between 1953 to 1959, and noted that the greatest cost increases occurred in the first year of service for families. They hypothesized that this was due to caseworkers providing the highest level of assistance during the first year. The researchers cautioned interpreting the findings of increased costs negatively, because overall public assistance expenditures for all St. Paul families increased 48% during the same period (p. 12).

Cambridge-Somerville Study

Unfortunately, the findings from the St. Paul Project were not widely disseminated. Despite this problem, other family-based programs emerged. Some of the newly-developed programs dispensed "visiting" professionals such as teachers, nurses, and social workers to the homes of families who required their services (Wasik, Bryant & Lyons, 1990). One such program, the Cambridge Somerville Youth Project, served boys at-risk for delinquency by sending "home visitors" or counselors to their homes and schools (Powers & Witmer, 1951).

Like the St. Paul project, this project included an evaluation and an elaborate assessment process for potential recipients. A controlled field study comprised the evaluation. All six- to seven-year-old boys and their families in Cambridge and Somerville were eligible for participation. Schools were asked to submit the names of eligible boys. A series of tests, including psychological tests, teacher interviews and records, physical exams, court records, and school and social service records were collected for each child (pp. 45- 48). In addition, social workers visited the homes of 839 boys, and completed a Home Visitor Schedule through interviews with the principal caregivers. The Schedule assessed the child's developmental history, personality, interests, attitudes towards school and religion, parental

education and employment, parental personality, and methods of discipline. Other domains, such as relationships with siblings, conditions in the home, and conditions in the neighborhood, also were assessed (p. 38). After gathering this information, a three-judge panel matched pairs of boys, and flipped a coin to determine treatment or control group participation.

Treatment and control groups were of equal size ($n = 325$). The treatment group boys were matched with a "friendly home visitor" who encouraged and guided the boys. The visitors had the use of other community resources at their disposal. However, the visitors were discouraged from providing financial assistance, or attempting to alter the socioeconomic context of the family. Control group boys received no treatment.

Fourteen assessment tools were administered to boys in both groups. Eight tools were used for the first survey and included the Vineland Social Maturity Scale, Furfey's Test for Developmental Age, The California Test of Personality (one section), The Haggerty-Olson-Wickman Schedules, the Altruism Scale, school records, police records, and official court records (p. 296). The second survey included six tools: the Fels Parent-Behavior Ratings, the Boys' Activities Schedule, the Boys' Interest Schedule, the Boys Vocational Future Ratings, the California Test of Personality, and the School schedule A (p. 296).

During the first survey period, the researchers found that scores on six of the eight measures favored boys in the treatment group, although no statistically significant differences were found (p. 303). During the second survey period, the scores on four of the six measures favored the treatment group. Again, no statistically significant differences were found for the total scores on the measures, although statistically significant differences were found between the treatment and control group on a number of individual items (pp. 304-305).

The researchers concluded that the degree and nature of emotional maladjustment was a key factor in determining outcomes. Also important was the quality of the parent-child relationship, and the home situation. Finally, the researchers suggested that a "friendly relationship" was not enough to prevent delinquency, stating that prevention services were required that focused on the specific needs and problems of each boy and his family (p. 547).

New York City Youth Board and Department of Welfare

Other projects developed simultaneously in other parts of the country. The New York City Youth Board and the New York Department of Welfare established a joint service project focusing on families who required support to address the problem behaviors of their

children (Overton, 1953). The project was based on philosophies that are the foundation of family-based services. Overton wrote, "the family as a unit had a cohesive power; the interaction between family members created a mutually supportive quality that made the unit stronger than the sum of the individual members" (p. 305). Thus, Overton supported both the notion of family strengths and the focus on the family as the unit of analysis. Furthermore, Overton (1953) described project services as moving away from psychoanalysis to focus "more on social relationships and reality problems than on intrapsychic conflicts" (p. 309).

Several features were evident in these projects that were adopted in later family-based initiatives. First, the efforts were directed toward the entire family rather than individuals. Second, problems were not considered to be deficits of the individual or the family, but instead were considered to be situational (i.e., poor housing, poverty). Third, services were delivered in the home and community of the family. Finally, the impact of the project upon the family was evaluated.

Family-Based Practice Methods and Research

Overton's observations paralleled the emergence of family therapy as an innovative treatment strategy during the 1950s and 1960s. Pioneers in family therapy and family systems research (Bowen, 1978; Haley, 1963; Minuchin, Montalvo, Guerney, Rosman, & Schumer, 1967; Satir, 1983) experimented with treatments addressing the family as a unit within various clinical settings.

Murray Bowen

Murray Bowen (1978) is considered a key contributor to family systems therapy based on his applied clinical efforts working with families who had a member diagnosed with schizophrenia. In 1957, he and his colleagues conducted a family therapy research project on a hospital ward with schizophrenic patients. They observed that patients appeared to progress in their treatment until they were visited by family members (such as their mothers). Following these visits, many patients deteriorated or regressed. To respond to this phenomenon, the therapists asked mothers of the patients to live on the hospital ward and participate in treatment. Based on this experience, other family members later were included. Bowen's efforts influenced the conceptualization of mental disorders: they no longer focused exclusively on understanding the individual, but also included understanding family dynamics.

Jay Haley

Haley (1963) also was a well-known contributor to the family therapy movement. He believed that the psychopathology of a person was the result of relationships with his or her family members. Although families have complex relational and communication patterns, Haley recognized that families sought a form of balance or homeostasis (p. 160). He suggested that family members attempted to control or influence other members in a struggle for power (pp. 161). Haley's methods often were referred to as strategic family therapy.

Salvador Minuchin

Another group of therapists who worked with troubled families was that of Minuchin, Montalvo, Guerney, Rosman, and Schumer (1967). This group was interested in treating delinquent boys and their families, and studying the effects of treatment. They believed that existing service efforts with families attempted to "remake the family's influence without first carefully studying those influences" (p. 5).

The therapists selected 12 boys and their families for the study, and matched them to a control group of nondelinquent boys and their families. All of the families were tested with a pictorial projective technique, the Family Interaction Apperception Technique (FIAT). The treatment boys and their families participated in 30 weekly sessions at the Wiltwyk Residential Treatment Center. All family members above the age of six participated in the sessions. General treatment goals included restoring parents to the head of the family, increasing communication between parents and children, and modifying the behaviors of the sibling group (p. 11). The treatment modality became known as structured family therapy.

Although not an experimental design (the sample was not selected randomly, and post-test data were not collected for the comparison group), the researchers suggested that 7 out of 12 of the treated families were judged clinically to be improved. Families that improved were reported as having expanded their range of coping strategies, and having experienced a greater range of emotions. The parents appeared to accept their parental roles more often, and exercised more effective control. The spousal subsystem appeared stronger, and the siblings became differentiated as a subsystem (p. 350). The researchers recognized that the findings were limited due to the research design. Nonetheless, the findings provided support for the treatment methods.

Virginia Satir

Another well-known family therapist, Virginia Satir (1983), published her first text on conjoint family therapy in 1964. Like the other family therapists, she believed that treatment should be directed toward the family as a whole, not toward individual members. Satir began treatment with a 1 to 1 ½ hour intake interview of the entire family. During this interview, she focused on family rules, roles, relationships, and interaction patterns. Frequently, she used a Family Life Chronology. Information from the Chronology was gathered from the family, and provided insight into three families: the parents and their families when they were children; the parents as "architects" of their current family; and the "third family" — the families that the current children would create with their future spouses (p. 145). Satir emphasized building self-esteem and enhancing communication as key goals.

All of the therapists provided numerous contributions that are evident today in intensive family preservation services. First, the family unit is the focus of assessment and treatment. An individual's problems are assessed, but the problems are viewed within the context of family; specifically, how the problems affect family relationships and interactions. Treatment is then directed toward the individual, other family members, and the family group. Second, family members influence one another in an attempt to achieve a balance within the family. To treat an individual member means altering the current balance in the family, and this alteration must be assessed and addressed. Third, families have inherent strengths. These strengths are relevant to assessment and treatment.

Expansion of Family-Centered Services

Following the development of the family therapy methods, other family-based projects were initiated. These projects benefitted from the previous family-based projects, and family therapy movement. However, unlike the previous projects, the services were more delineated, and evaluations were conducted with increasing frequency and rigor. One such project was supported by the federal Social Security Administration. This demonstration project focused on social and family behavior in Chemung County, New York (Warren & Smith, 1963). The project utilized trained public assistance workers to provide intensive casework services, assess the family, and terminate services based on family progress (Wallace, 1967, p. 381). The goal of treatment was improved family functioning, rather than resolution of economic issues. To achieve this goal, treatment caseworkers had reduced caseloads (25 instead of 60), and linkages with different agencies.

Chemung County Project

An experimental design was employed to test the model. Twenty-five families were randomly assigned to the reduced caseload/enhanced service linkage condition (experimental group), and twenty-five families were randomly assigned to the large caseload/traditional services condition (control group). The researchers used the family assessment tool developed for the St. Paul Project and a second tool to measure improvements in both groups. No significant differences in individual and family functioning were found between the experimental and control conditions (Wallace, 1967, p. 389). The researchers attributed the lack of research findings to the fact that the treatment conditions differed little in service characteristics.

The Family Life Improvement Project

Other family-focused projects were developed with a prevention orientation, maintaining many of the same service principles of the previous projects. The Family Life Improvement Project in Newark, New Jersey, begun in 1964, was one of these well-developed programs (Geismar, Lagay, Wolock, Gerhart & Fink, 1972). It was designed to provide support to young, urban families before problems arose. It was a preventive, home-based effort that served 272 young, urban families through marriage counseling, child care guidance, job finding, referral to resources, and worker advocacy with health or public assistance agencies. A control group ($n = 283$) did not receive any of these services.

Again, the St. Paul Scale of family functioning was used to assess change. Both groups were followed for a five-year period, and researchers found that treatment families experienced greater overall positive movement in three areas of family functioning: care and training of children; home and household practices; and health conditions and practices. They did not find differences between the groups in the areas of family relationships and unity, individual behavior and adjustment, social activities, economic practices, or use of community resources (Geismar, Lagay, et al. 1972). From the findings, the researchers provided suggestions for future prevention initiatives with young, urban families (Geismar & Krisberg, 1966).

Tensions Within the Foster Care System

Paralleling the development of family-based projects and therapies during the 1970s was another phenomenon. Foster care, the predominant out-of-home social service provided to abused and neglected children by child welfare agencies, was receiving increasing criticism for leaving children "adrift" away from their families within the service system (Shapiro,

1976). A number of projects were designed and implemented to address this issue. The Child Welfare League of America (Sherman, Phillips, Haring, & Shyne, 1973) conducted numerous demonstration projects. One of these projects identified children already in foster care who were most likely to return home, and the speed of that return. This project was specifically designed to identify and counteract "foster care drift."

For this demonstration project, the researchers (Sherman et al., 1973) found that out of 312 children in foster care, the case plan for only 29 percent was return to the biological parents. At the end of the 10 month study period, only 16 percent had been returned (p. 572-573). The researchers also found that permanent foster care was considered the plan for a large number of children in the foster care system. These findings raised questions regarding the appropriateness of permanency plans for foster care children. The researchers also believed that the findings provided support for the need to develop alternative services for these children.

Alternative projects were developed to serve families at risk for child abuse within the public child welfare system. The Lower East Side Family Union in New York (Weissman, 1978), and the Iowa Family-Based Services Project (Jones, 1985) targeted the unnecessary placement of abused and neglected children from their families. Like the previously developed projects, these projects focused on the family unit, and provided intensive services within the home and community. These projects and others that followed, also represent the first formal link between these types of services, and the policy goal of preventing out-of-home placement and foster care drift.

Emergence of Intensive Family Preservation Services (IFPS)

The best-known and most frequently cited IFPS program is the Homebuilders Program of Catholic Social Services in Tacoma, Washington, although the Family-Based Services Project (Jones, 1985) was similarly structured. Developed in 1974, the Homebuilders program provided staff who worked with families in crisis to help prevent the removal of family members (usually children at risk for abuse or neglect) to alternative living situations (Kinney, Madsen, Fleming & Haapala, 1977). The staff were "on call" 24 hours a day, 7 days a week, in order to respond quickly to the families. Intensive individual, marriage, and family counseling; anger management; skills training; teaching; and provision of concrete services were the types of services provided during a four- to six-week period to help resolve the immediate crisis, and to help prevent future crises (p. 668).

The Homebuilders IFPS model was a further improvement on previous family-based service projects. It was guided by several theories (Kinney, Haapala, & Booth, 1991; Whittaker,

Kinney, Tracy, & Booth, 1990). For example, ecological theory was particularly evident in assessment in areas such as work, school, and extrafamilial relationships. Maslow's Hierarchy of Needs (Maslow, 1954), in which families' basic needs (i.e., food, housing) are met was an integral component that IFPS workers would pursue with families. Caplan's Crisis theory (Caplan, 1964) provided the foundation for the length of service (i.e., four to six weeks) provided during IFPS. Caplan believed that normative crises (including removal of a family member) lasts four to six weeks. During that timeframe, individuals and families are more likely to accept outside help in order to alleviate the crises. Finally, family systems and social learning theories also were present in IFPS. Techniques and strategies which recognize the interrelationship of family members, and which are directed towards the teaching of new parenting skills are derived from family systems and social learning.

In addition to an articulated theoretical base, the Homebuilders project included a non-experimental evaluation (Kinney, Madsen, Fleming & Haapala, 1977). Evaluation data revealed that 97 percent of families who participated in the program remained together in the home for at least three months after completing the service. Data regarding the cost savings from the diverted placements also were reported (p. 671). Unfortunately, information was not reported regarding the functioning of the children or families after having participated in IFPS.

Relationship of IFPS to Prior Service Efforts and Practice Methods

The Homebuilders IFPS model draws heavily from components of prior service efforts and therapeutic advances cited previously. These components include

- Focus on the family unit
- Emphasis on multiple services, both clinical and concrete
- Provision of treatment in the home and community
- Intervening in family subsystems
- Recognizing and utilizing family strengths

All of these components represent contributions from the earlier work. Although some previous efforts included information on cost effectiveness, the emphasis on prior efforts remained on the functioning of the participant children and families.

Influence of Federal Policy

The problems of the foster care system, and the methods of IFPS became integrated with the assistance of federal policy in the early 1980s. A number of initiatives received limited federal recognition and support through the enactment of Public Law 96-272, the Adoption Assistance and Child Welfare Act of 1980. The law provided regulatory incentives and a small amount of funding for the development of placement (foster care) prevention programs. IFPS began to be viewed as a placement prevention program to access this funding and respond to the policy mandate. The law required that state child welfare agencies make "reasonable efforts" to prevent the removal of children from their homes. Foster care and other out-of-home services were to be employed only if preventive efforts within the home were not successful (Congressional Record, 1980).

Ironically, Public Law 96-272 redirected states' child welfare efforts in ways that were compatible with IFPS philosophies. Unfortunately, avoidance of placement and the resulting cost savings became the focal point of this federal policy and other cost containment strategies (e.g., state block grants) in the 1980s. Thus, when IFPS is viewed from the perspective of this short "history" of federal recognition and support, it is not surprising that IFPS sometimes has been viewed as an ineffective program dedicated to saving money through placement prevention at the expense of child safety. However, IFPS also may be viewed from the perspective of its "long past."

Redirecting the Focus

The longer term view of IFPS reveals roots dating back to charitable, family-based work of the 1920s. This period was followed by the emergence (and distraction) of the individually focused, pathology-oriented theoretical developments in the 1930s and 1940s. Despite this focus on the individual, the concept of strength-based assessments emerged in the 1950s and was accompanied by the development of family-based projects and therapies during the 1950s and 1960s (e.g., family systems theory, conjoint family therapy, structured family therapy, strategic family therapy). Most recently, these projects and therapeutic methods have been integrated formally into today's well-known IFPS models by modern pioneers, such as the Iowa Family-Based Services Project, and the Homebuilders of Tacoma.

It is important to note that this "long past" of IFPS included landmark programs like the St. Paul Project (Geismar & Ayers, 1959), the Cambridge-Somerville Youth Project (Powers & Witmer, 1951), the New York City Youth Board and Department of Welfare Project (Overton, 1953), the Wiltwyk Residential Treatment Center Project (Minuchin, et al. 1967), the Chemung County Project (Warren & Smith, 1963; Wallace, 1967), and the Family Life

Improvement Project of Newark (Geismar, et al. 1972). All of these projects employed evaluation strategies that attempted to measure improvements in child and family well-being and functioning. Although evaluation designs often were inadequate, and data collection and analysis primitive by today's standards, issues frequently measured included: basic needs, poverty reduction, physical health, economic independence, child care, truancy, family relationships and unity, family functioning, use of community resources, home management practices, child development, disciplinary methods and sibling relationships, and others.

The issues reflected in these measures are the same issues that IFPS workers today are concerned about when they interact with families. All of these items may relate to whether or not a child or family has improved. They also may relate to the decision about whether or not to place a child in out-of-home care. Unfortunately, however, the only evaluation datum frequently recorded is the placement decision itself.

The focus on placement prevention, driven by cost containment concerns, has not served practitioners or families well. The placement prevention emphasis has taken much of the attention away from the development of effective, family-focused, strength-based interventions that historically have been the substance of IFPS, and the programs from which IFPS evolved. It is time for researchers and policymakers to rejoin the practice community in the endeavor of improving interventions. Evaluators of IFPS should refocus their efforts to accomplish the following tasks:

- Examine the variety of treatment strategies and modalities employed by different IFPS programs to serve different types of families. In addition, it is important to identify the aspects of individual child and family functioning that are influenced by the different strategies.
- Develop new ways of assessing families and measuring family functioning that support case practice, in addition to providing good research and evaluation data.
- Employ more nonexperimental and quasi-experimental designs that focus on treatment outcomes, differentiating what types of services and strategies are most effective with different types of families.
- Recognize and address the shortcomings of conducting experimental evaluations of IFPS. When conducting experimental evaluations, clearly define the independent (treatment) and dependent (outcome) variables so that the results of the evaluations do not suffer from methodological and implementation limitations.

It is incumbent upon the practice community, evaluators, program administrators, and policymakers alike to reflect upon the long past of IFPS, not just the documented, short-term history of IFPS, and to take a comprehensive and informed view of what IFPS can

accomplish, and for whom. By understanding the roots of IFPS, and refocusing current attention on the many components of IFPS, all of these groups can return to the business of determining the most effective interventions for families receiving services from IFPS programs. Focusing on the most effective services will result in the prevention of otherwise unnecessary placements, and placement prevention will become subordinate to the outcomes of improved family and child functioning and child safety.

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Collaborative Conversations for Change: A Solution-Focused Approach to Family Centered Practice

Donald F. Fausel

The renewed interest in Family Centered Practice, prompted by the funding of Family Preservation and Support Programs, has created a need for training practitioners at a number of different levels and for a variety of roles. This paper will describe a training program for Family Centered Practice. Building on an empowerment model, the author presents an approach for working with families and children that views the tragedies of the past as resources, rather than the major cause of present problems. Collaborative Conversations for Change adapts the solution-focused therapy model to nontherapy roles that are required for a program to be family centered. Although these roles are not therapy, they are nevertheless therapeutic and reinforce clients' strengths. These collaborative conversations, however brief they may be, recognize that the client is the expert on his/her pain and struggles and the practitioner is the expert on assisting her/him plan change. Additionally, illustrations from a cross-cultural perspective demonstrate the utility of collaborative conversation in enhancing cultural competence.

Key Words: *collaboration; empowerment; family-centered; resilience; strengths*

It is well documented that many families do not receive the help they need to maintain minimum safe home environments for their children, let alone provide optimal conditions for growth and development (Brown, & Weil, 1992; Downs, Costin, & McFadden, 1996; Helton, & Jackson, 1997). Recently, the federal government took steps to address the needs of families who face stressful circumstances and needed support and other services to prevent abuse and neglect from occurring. In 1993, Congress passed the *Family Preservation and Support Act*, an amendment to Title IV-B of the Social Security Act. This Act authorized funding to states of nearly one billion dollars over a five-year period and prescribed two types of services: *family support services*, available to all families in the community on a voluntary basis and *family preservation services*, designed to maintain the family unit and avoid placement in substitute care and to promote family reunification after children have been placed outside the home (Highlights, 1994; Downs, Costin, & McFadden, 1996).

This paper will focus primarily on family support services. Specifically, it will adapt a solution focused approach, Collaborative Conversations for Change (CCC), to a Family-Centered Practice (FCP) model. It will utilize the author's experience in developing and delivering training modules for personnel of community coalitions, receiving family support funding, that adapt a solution-focus to family-centered practice. After briefly tracing the history of the *strengths* and *empowerment* tradition in social work practice, the paper will demonstrate the utility of these concepts in a family-centered model that uses a solution-focused approach. Finally, we will describe how concepts of strengths, empowerment and solutions, that have been defined and discussed, and are used in several training modules, developed to teach family-centered practitioners in programs funded by a State's Title IV-B money.

Everything Old Is New Again!

Just as we as a nation, have periodically rediscovered poverty, so, from time to time, the profession has rediscovered the empowerment and strengths perspective in micro and macro practice (Mauccio, 1981; Pinderhughes, 1993; Weick, Rapp, Sullivan & Kishardt, 1989; Saleebey, 1992; DuBois & Miley, 1992; Davis, 1994; Gutierrez, & Nurius, 1994; Lee, 1994; Simon, 1994). In 1983 Howard Goldstein wrote an article, *Starting Where the Client Is*, in which he reminded us that client-centeredness, basically a strengths perspective, had been a hallmark of social work practice from the days of Mary Richmond. He traced the dictum of starting where the client is, through the work of Richmond, Gordon Hamilton, who pointed-out the significance of the "client's own story," through the functional school of social work, Helen Harris Perlman, Max Siporin down to Caryl Chessman and Alex Gitterman.

What seems apparent from even a cursory review of the history of the social work profession, is that although the profession has often given lip-service to the empowerment and strengths perspective, more often than not, we have not put our money where our mouth is, as it were, and have allied ourselves with other professions and models that base practice on clients' deficiencies, pathology, and failures (O'Melia, DuBoise & Miley, 1994; Berg & DeJong 1996). The allegiance to the medical model, with its linear, cause and effect view of problems and problem solving, evolved over time for reasons that are historically understandable, but beyond the scope of this article.

Perhaps the social work profession has not only been an "unfaithful angel" in our abandoning the poor as Harry Specht and Mark Courtney (1994) have suggested, but our unfaithfulness may be equally true of our abandoning our heritage of the strengths

perspective that is so crucial for empowering families and children, as well as other oppressed populations that we are mandated to serve (Weick & Saleebey, 1995).

Family Centered Practice

Family-centered practice was first conceptualized as *family centered casework* by Frances Scherz (1953). During the 1970s, it took the form of *family preservation programs*, which proliferated over the next twenty years. These child welfare programs, were primarily designed to prevent out-of-home placement and used a family-centered or family-based approach to service (Whittaker, Kenney, Tracy, & Booth, 1990; Kaplan, & Girard, 1994; Schuerman, Rzepnicki, & Littell, 1994; Cole, E., 1995; Pecora, Fraser, Nelson, McCoskey & Meezan, 1995). Family-centered practice was the subject of renewed interest with the publication of Hartman & Laird's book, *Family-Centered Social Work Practice in 1983*.

In the past five years, publications on family-centered practice and its key concepts, empowerment, resiliency, and strengths, have found a new generation of readers (DuBoise, & Miley, 1992; Saleebey, 1992; Berg, 1994; Berry, 1994; Cowger, 1994; Davis, 1994; Lee, 1994; Gutierrez & Nurius, 1994; Anderson, 1995; Cole, 1995; DeJong, & Miller, 1995; Weick, & Saleebey, 1995; Gilgun, 1996; Powell, 1996; Saleebey, 1996)

Another indicator of the renewed interest in family-centered practice was the publication of two separate special issues of *Families in Society*, completely devoted to family-practice, with the majority of the articles focusing on family-centered practice (March, 1995; November, 1996). The March 1995 special issue was the 75th Anniversary issue of the journal and included articles on both practice and education for family-centered practice. The November 1996 special issue applies family-centered practice concepts and skills to six different family constellations. It is interesting to note the original title of the journal was *The Family*, and for fifty of its seventy-five years had *Social Casework* in its title. The change in journal's titles from family, to social casework and back to families, parallels the profession's change in focus from family, to individual, to family.

Definition and Characteristics

Hartman & Laird (1983) define family-centered practice descriptively, as a model of practice that locates the family as the center of the unit of attention or field of action for intervention. Based on a systems/ecological framework, this approach to helping grows out of the basic premise that human beings can best be understood and helped in the context of the intimate and powerful human system of which they are a part. Family-centered practice focuses on the needs of the entire family rather on an individual member. The family-

centered practitioner offers an array of assistance, both concrete and therapeutic. Even when a practitioner is working primarily with an individual, he/she must "think family." Family-centered work is a way of thinking about individuals in their family and community context, not simply a set of techniques for working with a family.

The domain of family-centered practice is not restricted to the nuclear or extended family. It includes the larger environmental systems, which might impact the family. Family centered work is more effective, when it addresses the effect of the environmental stressors on families. Ignoring the environment's effect on families limits the change that can be created (Hartman & Laird, 1983).

Though family-centered practice draws from family therapy theory and techniques, it is not family therapy (Morton, & Grigsby, 1993). It is similar to family therapy, in that it employs the ecological/systems framework. It also draws eclectically from family therapy modalities, yet it differs in that its interventions, not just its assessments, extend beyond the individual family and extended family to the neighborhood and the community in which the family lives. Unlike family therapy, whose theory base tends to focus on nuclear and intergenerational families, family-centered practice draws its knowledge and skills from both micro and macro practice and prescribes a continuum of services at different levels of intervention (Brown, & Weil, 1992).

Collaborative Conversations for Change

Collaborative conversations for change is an effort to operationalize the family-centered practice model by applying the concepts and skills of Solution-Focused Brief Therapy, developed by Steve deShazer and his colleagues at *The Brief Family Center* in Milwaukee (deShazer, 1991; Berg, 1994; DeJong, & Miller, 1995; Berg, & DeJong, 1996), to the different roles, not just the clinical role, expected of family-centered practitioners.

There are a number different modalities that could be used with a family-centered model, e.g., family-centered practice could be used "... in combination with a structural approach, communication theory, social learning theory, reality therapy or solution-focused brief therapy" (Kaplan, & Girard, 1994, p.58). The fact that this paper has chosen to draw more heavily on the solution-focused approach is not to suggest that other approaches might not be equally appropriate. It reflects the author's belief that assisting families look for those times when they are able to cope with life's problems or those times when they are already overcoming what they present as a problem, however small a step that might be, is more compatible with the strengths perspective, than some of the other approaches, which tend to be more prescriptive and more practitioner driven than client driven. Focusing on

strengths fosters empowerment and works well in keeping the worker off the side-roads of pathology (DeJong, & Miller, 1995).

Another reason for the choice of a solution-focused model is that it is easily applicable to a number of different roles that practitioners delivering family-centered services apply at a number of different levels. Understandably, the solution-focused brief therapy approach to working with families has mainly focused on the role of therapist or clinician, who is often perceived as being confined to her/his comfortable counseling cubicle giving prescriptions for clients to follow. However, so many roles in family-centered practice are performed by practitioners who do not consider themselves *therapists* but provide services that are *therapeutic* and crucial to the family-centered approach. While the solution-focused approach has demonstrated its effectiveness in therapy sessions (DeJong, & Berg, 1996), it has not been tested with nonclinical roles. Nevertheless, there is no reason to believe that its philosophy and many of the techniques can be equally useful to

- a family support specialist, who has a casual supportive conversation with a client, while driving him/her to the health clinic
- a case manager, who in making a referral, has an opportunity to plant a seed of strength that the client can reflect on
- a child protective service worker, while investigating charges of neglect, can subtly acknowledge behaviors that can be or have been empowering for the client
- a classroom teacher, who can ask parents the appropriate questions to point-out how impressed they are with the ability of the family to cope with severe stressful situations
- a community worker attending a family picnic that the client-family is attending to casually wonder, how the family manages as well as it does
- a day care worker acknowledging the coping skills of a single parent as she picks up her child from the center
- a trained volunteer, participating on a committee with a client-family member to plan an activity, taking advantage of the opportunity to express her/his admiration for the client's community involvement, despite family responsibilities

Doherty (1994) distinguished five levels of involvement with families that practitioners might assume. These levels range from a minimal emphasis on families, providing advice, information about resources as well as meeting concrete needs, through levels that are more associated with therapy, up to level five, which is providing family therapy. One practitioner might deliver the service at all five levels, but more often than not, the services are delivered by different practitioners, with different roles and different knowledge and skills. This article intends to apply collaborative conversations to all five levels of interactions with families, not just the clinical levels.

Laird (1996) points out that "... few family-centered constructionist theorists have moved beyond the therapeutic conversation to the larger social realities that surround the individual narratives" (p. 160). I would agree and also suggest that few theorists have moved in the other direction, that is, to apply therapeutic conversations to nontherapy situations that are concerned with the individual narrative, but do not involve short or longer term therapy.

Collaborative Partner or Expert Practitioner

The debate between "strength or pathology" is well documented in the literature (Goldstein, 1990; O'Melia, DuBois & Miley, 1994; Saleebey, 1996; Miley, O'Melia & DuBois, in press). It is difficult for practitioners, who are more inclined by training or disposition to look for problems and deficiencies, (pathology), to take a strengths perspective. Even though most therapy approaches include strengths in their assessment, listing strengths is usually an *add-on* and not the major thrust of their work with clients (Berg, & DeJong, 1996; Saleebey, 1996).

It is also well documented in constructionist literature on empowerment, the strengths perspective, narrative and solution-focused therapy, that practicing from an expert position, with its emphasis on diagnosis, treatment, including prescriptive interventions, is disempowering (Gergen, & Kaye, 1992; Hillman, & Ventura, 1993; Laird, 1995; Berg, & DeJong, 1996; Saleebey, 1996).

Laird in her 1995 article on *Family-Centered Practice in the Postmodern Era*, explores the long-held assumptions about assessment and intervention and the implications for social work practice. She suggests that the very terms diagnosis and treatment are not compatible with family-centered practice, because they tend to project the professional as the powerful expert. She quotes Gergen and Kay (1992), who suggest that "... the very structure of the process furnishes the client a lesson in inferiority ... (and) the therapist is positioned as an all-knowing wise—model to which the client can aspire" (p. 171).

Family-centered practice is based on a *strengths perspective* that views the tragedies of the past as resources, rather than the major cause of present problems. The client is viewed as the expert on his/her pain and struggles and the practitioner as an expert in assisting the client make the changes they are seeking (Cowger, 1994; Saleebey, 1996). The practitioner assumes what Anderson & Goolishian (1992) refer to as *the not-knowing* approach, a *one-down position*, which is a difficult switch for those of us who have been trained to be the expert.

To be genuinely collaborative, not only do we need to take a more *partnership position* in relating to client families but we also need to adopt a new language for the helping process. Powell (1996) suggests that family-centered practitioners are moving away from directive, hierarchical, and expert stances toward more collaborative coaching approaches. He proposes a schema that he describes as "... a journey whereby a troubled family, guided by a family-centered worker, can find a more satisfying life" (p. 446). In order to make the interaction with the family and the practitioner more collaborative and more of a conversation or a chat than an interview, he recommends using the following terms to describe the helping process: *Joining*-----*Discovery*-----*Change*-----*Celebration*-----*Separation*-----*Reflection* (p. 446). He goes on to discuss the six stages of the process in more detail. Briefly, *Joining*, or engaging the family is the first step in relationship building; *Discovery*, is the process of helping the family explore and nurture their strengths; *Change*, rather than treatment, implies a positive connotation, possibilities, a future orientation; *Celebration*, involves acknowledging and appreciating the family's strengths and potential; *Separation*, recognizes that clients leave, at least for the time being, with a greater ability to cope, rather than termination, which sounds so final and practitioner-centered; finally, *Reflection*, which reveals what we have learned as practitioners and represents an opportunity for research/evaluation.

In the same vein, Furman (1994) and Hoyt (1994), use the term *solution talk*, to indicate the posture that a practitioner takes to lead the conversation in such a way that the emphasis is on solutions. In addition to moving from an interview to a conversation, talk, or chat, a number of authors question the use of labels or names for *troubles* that individuals are experiencing (Brown & Weil, 1992; Berg, 1994; Furman, 1994). Outside of acting as a short-hand for referring to a complex problems with just a few words, labeling is rarely an innocent description of the problem. More often than not, a label has embedded implications of the problem's origins, prognosis, or treatment. "For example, the term *borderline personality disorder* and *having trouble* can both be used to refer to an adolescent with multiple problems" (Furman, 1994, p. 42). Both terms create very different impressions about the problem.

A collaborative conversation also avoids causal explanations. Insights and explanations often imply blame, which has the effect of destroying collaboration and creativity, causing defensiveness and anger (Furman, 1994). Rather than hypothesizing about the cause of the problems, a collaborative conversation focuses on other themes, such as the family's vision of the future, the progress they have made, or a solution that might have been helpful.

The Strengths Perspective

Rather than looking at families as "multi-problem" families, who are often defined by their deficits, the family-centered practitioner looks at "multi-needs" or "high risk" families, that have strengths that are important to recognize and a capability for resiliency (Gilgun, 1996; Kaplan, & Gerard, 1994). Rather than looking for failures, the family-centered practitioner looks for exceptions and solutions. They look for those times when the family is doing well—those times when the clients are already coping with the problems they are presenting (Weick, & Saleebey, 1995; Berg, & DeJong, 1996).

The family-centered practitioner believes that families are (1) resilient; (2) not perfect, but that all people and environments possess strengths that can be marshaled, despite horrible things that might have happened to them in the past and despite life's on-going problems; (3) resourceful; (4) want to improve their circumstances; (5) despite many obstacles, somehow, they do keep going and make it through each day; (6) are the experts on what they need; (7) most multi-need families have a healthy distrust of the social service system, and that distrust must be respected; (8) motivation is fostered by a consistent emphasis on strengths as the client defines these; (9) able to discover strengths, but it requires a process of collaboration between the client and the practitioner (Dunst, Trivette, & Deal, 1994; Kaplan, & Girard, 1994; DeJong, & Miller, 1995; Gilgun, 1996).

Empowerment

Kaplan & Girard (1994) suggest that empowerment is the cornerstone of family-centered practice. Empowerment means helping families gain access to their power, not giving them power. "The empowerment process resides in the person, not the helper" (Lee, 1994, p.13).

The process of empowering families requires first and foremost that the worker believes in the family's ability to change, that he/she provide families with a new perspective on their lives, by recognizing with them the strengths that they might not know they have and helping them build on those strengths and resources, and finally supporting and strengthening the family's cultural and ethnic background (Kaplan, & Girard, 1994).

There are some who believe that *empowerment* is the latest fad and a cliché that social work has latched on to, or suggests that *empowerment* is too weak a word, while others "... have suggested that *liberation* more accurately describes processes and objectives that challenge oppression" (Lee, 1994). The key word is oppression. Much of the initial thinking and writing about empowerment, was focused on those populations that were the most oppressed, who had the least power—the poor, women, people of color, and gays and

lesbians—the same populations that are part of the profession's mission to serve (Gutierrez, 1994).

Cultural Competence

Since empowerment is so connected with assisting the disenfranchised access their power, it is obvious that a workers practicing an empowering approach would need to have a high degree of cultural competence and an understanding and ability to work with diverse populations. Cross' (1988) definition of cultural competence could apply equally to other diverse groups, e.g., gays and lesbians or persons with disabilities. He defines cultural competence as:

A set of congruent behaviors, attitudes, policies and structures which come together in a system, agency or among professionals and enables that system, agency or those professionals to work effectively in the context of cultural diversity (p.13).

The models that Devore and Schlesinger (1991) developed for ethnic-sensitive social work practice and/or the diversity model of Helton and Jackson (1997) fit particularly well with the strengths and empowerment perspective. Rather than just focusing on the strains and strife, which are indeed a reality, their focus is that ethnicity is a source of cohesion, identity, and strengths. Too often people remember part of their story, usually the bad things that have gone on in their lives and forget how they managed to survive and cope with adversity and how those same skills can be applied to current situations.

Family-centered professionals need to acquire knowledge of (1) the impact of the family's cultural history, (2) the role that acculturation and assimilation have played, (3) the family's structure and how they communicate, (4) cultural norms and values, (5) how they can best show respect to a particular family from a particular culture, (6) what are the acceptable help seeking and problem solving behaviors, (7) the informal sources of help in their environment, e.g., Church, spiritual and traditional healers, natural helpers, extended family etc. (Cross, 1995).

Family-Centered Practice Training

The mission, goals, and objectives of family preservation and support services for the State of Arizona's programs, funded by Title IV-B of the Social Security Act, all have a family-centered focus. In order to be funded, agencies needed to demonstrate that they were part of collaborative effort that included a number of agencies in their community and followed a family-centered practice model. As part of the contract, those collaborators that were

funded were mandated to require their staff to complete thirty hours of training (*Annual Progress and Service Report*, 1996). The list of the ten modules to follow, represent thirty hours of training available through *Behavioral Health Solutions*. This section will focus only on Module 2.

All the modules are intended to be covered in three-hour blocks of time. However, depending on the schedule of the participants, topics may be broken into one-and-a-half hours or may be presented in an all-day, six-hour workshop format. Each module contains its own goals and objectives, handouts and outlines for mini-lectures, activities, vignettes for discussion, and suggested video tapes to accompany the training. The content is contained in a training manual, *Family-Centered Practice for Family Support and Preservation Programs: A Solution-Focused Approach* (Fausel, 1996).

Before proceeding with the modules, it might be helpful to describe one of the twenty-six programs that was funded. *All Sines Point to Success*, was a collaboration of sixteen different community agencies including two schools, several social service agencies, the police department, several churches, and the Child Protective Services agency. The title of the program, *All Sines Point to Success*, refers to one of the major collaborators, Sines School. The program focuses on two schools in a Zip code area, which led the entire state in CPS referrals per thousand the previous year. There are more than 6,200 children living in poverty, and the area has the highest number of low-income, single-parent, and minority households in the city. The area also has eighty-five percent of all the narcotic warrants in the city, seventy-five percent of which involve minors.

In addition to hiring two school-based social workers and two social work assistants, the program provides case management, support and referral services, and works closely with CPS. In addition, the program offers several other major projects that utilize the schools' facilities, and program staff. The projects are a *Twilight Summer Camp* and *Sine Saturday* along with a *Phone Friend*. All of these programs are community- and family-centered. The objectives of the *All Sines* program are to increase the safety of children in their family home; parenting competency/ effectiveness; the families' ability to resolve crisis; the capacity of agencies serving children and families to strengthen families (Directory, 1996).

Training Modules

The following are the ten training modules included in the training:

1. The Family-Centered Practice Model
2. Collaborative Conversations for Change: A Solution Focused Approach to Family-Centered Practice
3. Family-Centered Assessment
4. Collaborative Conversations for Cultural Competency
5. Working with Diverse Family Structures
6. Working with the Parent/Child Relationship
7. Working with The Spousal Relationship
8. Working with the Family with Violent Members
9. Working with the Families with Chemically Dependent Members
10. Empowering Practitioners through Reflective Supervision

The goal of Module 2 is to provide participants with an understanding of the assumptions of Collaborative Conversations for Change and the skills to apply a solution-focused approach to the family-practice model presented in Module 1. Eight objectives are identified, along with a list of key concepts that will be covered. After a brief review of the strengths perspective and empowerment presented in the first module, a mini-lecture and handouts on the guiding principles and basic questions used in a solution approach, along with stem statements, are provided the participants for discussion.

Module 2 focuses on the application of collaborative conversations to the nonclinical roles that a family-centered practitioner performs. It first explains and gives examples of the guiding principles and basic questions of solution-focused interventions; second, participants watch clips of a video illustrating the techniques; third, participants are asked to role-play some of the basic questions or solution-focused statements based on vignettes and stem statements.

There is extensive literature that explains the underlying assumption, philosophy, and techniques of solution-focused brief therapy (de Shazer, 1991; Walter & Peller, 1992; Berg, 1994; Chevalier, 1995; DeJong & Miller, 1995; Berg & DeJong, 1996). For readers not familiar with this approach, a recent article from DeJong and Berg (1996) provides an excellent summary of solution-focused brief therapy. The article describes the philosophy and the basis questions and responses that a solution-focused brief therapist would use. It explains the use of exception questions, scaling questions, the miracle question, coping questions, normalizing questions, and the importance of feedback.

One of the exercises in this module, for practicing nonclinical roles, uses stem statements. Participants are asked to not use the same type of solution-focused response for more than one stem statement. The instructions are

For each of the following statements, answer with a solution-focused response:

1. Family support specialist: You're driving a single mother to a health clinic meeting. You know she has been having trouble with her teenage daughter; the mother says, "I have no idea how to handle Sara; she's getting beyond by being able to help her."
2. Social work assistant: Working in a school setting during recreation, an eight-year-old girl complains, "None of my classmates want to play with me."
3. Case manager: Meeting with parents who have had a history of being verbally abusive to one another. "I hate it when we put one another down. I know it isn't good for the kids to hear."
4. CPS worker: Investigating a call from a day care center that the woman's two-year-old consistently drops her child off at the center without having had breakfast or being bathed. There also is a concern that the child has been left alone for periods of time. "I don't know why you social workers keep sticking your nose in my business."
5. A community worker: Discussing an up-coming meeting with a welfare mother at her kitchen table. "I feel scared of talking in front of all those educated people at those meetings."

After pairing-off and going around the room with each statement in a *round-robin*, participants are asked to follow-up with another solution-focused response to how their partner replied to the initial statement. For example, if the response to statement number one were, "Are there times now when you are able to handle her?" Then the partner role playing the mother responds and the person playing the family support specialist answers with another solution-focused response, etc. After everyone has a chance to role play, the facilitator guides a discussion about the strengths they see in each *client*; how the particular solution-focused question helped elicit strengths and how useful they thought even a brief encounter with a client might be. At the end of the session, participants are given the following suggestion:

Between now and the next time we meet, what I would ask you to consider— is to notice those times when you have an opportunity to try one of the responses you practiced and be prepared to share your experience with the rest of us next week.

Conclusions

Training for practitioners with nonclinical roles in family-centered practice programs is essential to the success of these programs. This paper has been an attempt to examine the major concepts of family-centered practice, i.e., *strengths and empowerment* and apply some of the skills of solution-focused brief therapy to roles that are not therapy, but nevertheless represent *therapeutic conversations* with clients. Obviously, there is need for research on the results of this training, which is not feasible at this stage of the funding. However, preliminary feedback from participants is very positive and attests to the usefulness of the material.

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Review of Current Resources

Social Work Practice with Children. Nancy Boyd Webb. New York: The Guilford Press.

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This book, intended as a text for both baccalaureate and master's-level courses, focuses on the special needs of children. Its premise is that social work education has not prepared students to use intervention methods that are developmentally appropriate to children.

The fifteen chapters are organized into four sections. The first section sets the framework for the approach of the book. Chapter 1 presents the current social context of children's lives and commits to the ecological perspective. Chapter 2 discusses the social work role, ethics, knowledge base, and competencies for working with children. The second section comprises three chapters organized around the helping process—relationship, assessment, contracting, planning, intervention, and monitoring. While the process is generic, the knowledge base and suggested tools are mostly specific to children. Numerous brief case vignettes and one longer case example, which runs throughout the chapters, are included.

The four chapters of the third section are organized around methods of working with children. Chapter 6 on family intervention convincingly states that when children have problems, family and child methods must be blended. Webb warns against using a family systems approach that sees the child only as an element of the family system and ignores the child's specific and individual needs. Likewise, she cautions against excluding parents from child treatment, thus reinforcing parental feelings of incompetence. Chapter 7, focusing on individual work with children, argues that the child's idiom is nonverbal and that all social workers, including those working primarily with adults, need some familiarity with basic play techniques. While several of the chapters are sketchy, Chapter 8 on group work seems particularly thin. Webb seems to acknowledge this with the statement that it is intended to encourage social workers to consider group as a viable modality in work with children. Chapter 9 recognizes school as a primary component of children's ecology and briefly presents some of the knowledge base for working collaboratively with school, home, and community.

The last section comprises six chapters that look at children in special circumstances: out-of-home placement, "nontraditional" (divorce, dingle parenthood) families, families experiencing illness and death, substance-disordered families, families experiencing violence, and families in a changing world.

Social Work Practice with Children has many strengths. the rich vignettes are written in similar, though not identical, formats that could serve as models for students learning to organize case material and present it coherently. Examples contain such elements as reason for referral, presenting problem, family information, biopsychosocial assessment, treatment plan, and discussion. Webb also uses many tools and aids, some borrowed from others and some her own, including the eco-map, culturagram, and developmental history outline. Tables, figures, and lists (e.g., problem syndromes, classification of disabilities, child equipment, interactive components of a tripartite assessment format), demonstrated over a range of cases, are handy references. There is liberal use of child art work, always with discussion included. Other resources (e.g., organizations, journals, forms suppliers, training programs) are strewn throughout the book or included as appendices.

Webb artistically draws upon older literature (e.g., Axline, Perlman, Vinter) and blends it with the new (e.g., Congress, Belsky, Webb). thus, the book feels historically grounded yet very current. The greatest limitation of the book is inherent in its purpose as a text. It covers a vast amount of material, attempting to correct our errors of the past in the omission of child material from social work education. Too often, the chapters skim the surface of their topics. While this is not inappropriate for a text, anyone familiar with Webb's previous works will long for the depth and richness found there.

The book certainly can be useful as an undergraduate or graduate text. As a beginning text on social work practice, its ecological approach, organization around the casework process, and many useful tools could effectively support teaching generic social work. As a text for teaching practice with children, its organization would reinforce and extend students' existing generic practice base as well as adding child-specific knowledge and skills. In addition, a practicing social worker who wants help in adapting good social work practice to work with children would find this book a useful starting place from which to pursue topics in more depth.



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